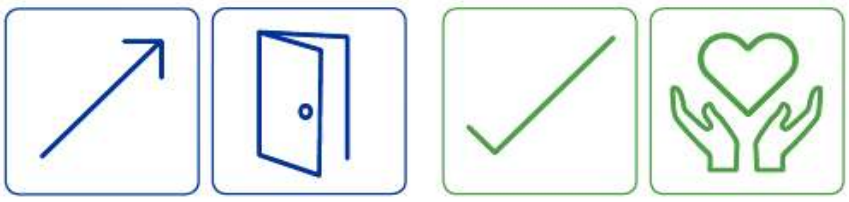
AMERICAN PSYCHIATRIC ASSOCIATION

IPS: THE MENTAL HEALTH SERVICES CONFERENCE

October 19-22, 2017 • New Orleans



ENHANCING ACCESS & EFFECTIVE CARE

Syllabus and Proceedings

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Courses

Thursday, October 19, 2017

Buprenorphine and Office-Based Treatment of Opioid Use Disorder
Director: John A. Renner, M.D.
Faculty: Petros Levounis, M.D., M.A., Andrew J. Saxon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Discuss the rationale and need for medication-assisted treatment (MAT) of opioid use disorder; 2) Apply the pharmacological characteristics of opioids in clinical practice; 3) Describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment matching; 4) Describe the legislative and regulatory requirements of office-based opioid pharmacotherapy; and 5) Discuss treatment issues and management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain.

SUMMARY:
This course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder (OUD) and review 1) *DSM-5* criteria for opioid use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of OUD; 2) confidentiality rules related to treatment of substance use disorders; 3) Drug Enforcement Administration requirements for recordkeeping; 4) billing and common office procedures; 5) the epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, and ADHD and how to distinguish independent disorders from substance-induced psychiatric disorders; and 6) common clinical events associated with addictive behavior. Special treatment populations, including adolescents, pregnant addicts, and geriatric, HIV-positive, and chronic pain patients will be addressed, and small-group case discussions will be used to reinforce learning.

Friday, October 20, 2017

How to Expand Your Practice With Telepsychiatry
Director: Jay H. Shore, M.D., M.P.H.
Faculty: Peter M. Yellowlees, M.D., Robert Lee Caudill, M.D., Steven Chan, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand how to select an appropriate model of telepsychiatry care and develop an integration plan for to match telepsychiatry model into a specific practice setting; 2) Understand methods for adapting telepsychiatry into various health care environments and solutions and best methods of successful integration of telepsychiatry into psychiatric practice; and 3) Comprehend how national standards and guidelines for telepsychiatry, clinical workflows, e-treatment team coordination, and APPS can be best adopted for the creation of telepsychiatric practice.

SUMMARY:
Telepsychiatry, in the form of live interactive videoconferencing, has reached maturity as a field and is being adapted in a wide variety of health care settings. It is demonstrating its ability to increase access to care as well as shift models of health care delivery. There are now many demonstrated successful models of providing telepsychiatric care. Identifying the most appropriate model of telepsychiatry for subsequent adoption into an individual psychiatric practice or organization is critical for building scalable and sustainable services. Successfully integration of telepsychiatry into an individual psychiatric practice or healthcare organization requires careful planning, development, and implementation. There are a core sets of issues and challenges around clinical standards, workflow and education that need to be address for successful integration to occur. The course will be taught by psychiatric national experts in telepsychiatry in highly interactive demonstration session with the audience. The course instructors will take the audience through the integration of telepsychiatry into two hypothetical practice settings; 1) Home-based private psychiatry and 2) Integrated Care Telepsychiatry service covering the salient administrative and clinical issues in the creation of such a practice. Administrative topics to be addressed will include needs assessment and

planning, model selection, legal and regulatory issues, resourcing and reimbursement and clinical needs. Live interactive mock video conferencing sessions will highlight important clinical issues including safety management, clinical process adaptation to videoconferencing, managing hybrid doctor-patient relationships and virtual team work.

Marijuana and Mental Health
Director: Dan Nguyen, M.D.
Faculty: Thida Thant, M.D., Marc Manseau, M.D., M.P.H., Taylor Black, M.D., Erica Rapp, M.D., Jesse Darrell Hinckley, M.D., Ph.D., Charles Luther, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify various dispensary and pharmaceutical formulations of medical marijuana as well as synthetic cannabinoids; 2) Describe how cannabis use impacts psychiatric illnesses including mood disorders, anxiety and psychosis; 3) Recognize the short and long term effects of cannabis use in adolescents; 4) Understand differences between highlighted medical marijuana programs as well as the current state and implications of current legislation; and 5) Know treatments for acute cannabis intoxication and cannabis use disorder.

SUMMARY:
Marijuana use is a controversial and provocative topic across the United States. Opinions about marijuana can range from it being a harmless natural plant with medicinal value while others view it as a substance of abuse with overstated benefits and understated risks. Despite the classification of marijuana on a federal level, marijuana use is becoming legalized by states across the U.S. and highlights the ambivalence about marijuana in our society. Research currently suggests increased teenage and adult use of marijuana in states with legalized medical marijuana with noted harmful effects for adolescents and those with psychotic spectrum disorders. With the increasing prevalence and availability of marijuana products, medical providers will need to become more informed and well versed about marijuana beyond the scope of addiction. This workshop will familiarize attendees with this new culture of legalized medical marijuana and its implications for psychiatry. This "Marijuana and Mental Health" workshop will feature presentations on: (1) an overview of the complex connections between marijuana and mental health; (2) medical marijuana, including pharmaceutical and dispensary formulations, efficacy in treating physical and mental health conditions, dosing, interactions and monitoring; (3) synthetic cannabinoids, including physiological, physical and psychiatric effects; (4) psychiatric complications of cannabis use, including impact on anxiety and mood disorders; (5) marijuana and psychosis; (6) short- and long-term effects of cannabis use in adolescents; (7) legislation and policy related to medical marijuana; and (8) the treatment of cannabis use disorder, including psychotherapeutic and pharmacological interventions.

Saturday, October 21, 2017

2017 Psychiatry Review and Clinical Synthesis
Directors: Philip R. Muskin, M.D., M.A., Tristan Gorrindo, M.D.
Faculty: Ilse Wiechers, M.D., M.H.S., M.P.P., Ashley Weiss, D.O., M.P.H., John W. Barnhill, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify gaps in knowledge in psychiatry and neurology through self-assessment; 2) List key diagnostic and treatment strategies for major disorders in psychiatry; 3) Create individual learning plans for addressing knowledge gaps; and 4) Convey a working knowledge of the various topical areas likely to be encountered during lifelong learning activities.

SUMMARY:
Using a "flipped classroom" design, participants will engage in a multi-week self-study exercise designed to increase knowledge and critical reasoning of essential psychiatric and neurology topics. On August 15th, 2017, registered participants for this course will receive by mail three textbooks. The first book, *Study Guide for the Psychiatry Board Examination*, consists of several hundred self-study multiple-choice questions (MCQ) including answers and explanations. The second book is a curated compendium of review articles from *FOCUS: The Journal of Lifelong Learning*, which have been

compiled to summarize current diagnostic and treatment approaches for major disorders in psychiatry. The third text is *Approach to the Psychiatric Patient*, a case-based exploration of psychiatric topics. Course participants are encouraged to use these materials to review major topics in psychiatry prior to attending IPS: The Mental Health Services Conference. During the live portion of this course, participants will work in small groups and with expert faculty in general psychiatry, geriatric psychiatry, child psychiatry, and consult-liaison psychiatry to complete a series of case-based vignettes that have been designed to illustrate high-yield and key learning points for major disorders in psychiatry. This eight-hour clinical synthesis session is designed to help learners integrate and apply knowledge through clinical vignettes and to reinforce key principles in psychiatry.

Sunday, October 22, 2017

Psychopharmacology in Child Psychiatry: A Clinical Course
Director: Mary Margaret Gleason, M.D.
Faculty: Vininder Khunkhun, M.D., Myo Thwin Myint, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Be able to describe the developmentally specific features of common psychiatric disorders in children and adolescents; 2) Be able to identify first and second line treatments for common child psychiatry disorders; 3) Be familiar with the strength of the literature supporting psychopharmacologic and non-pharmacologic treatments for youth; and 4) Be able to name non-proprietary measures to track treatment effects in children and adolescents.

SUMMARY:
Over 10% of children and adolescents experience a psychiatric disorder in a given year. There are only 8,300 child and adolescent psychiatrists in the country to serve the needs of an estimated 15 million children requiring care. Given this extreme workforce shortage, many children are seen by non-child and adolescent psychiatrists, including general psychiatrists and pediatricians. Child psychiatric disorders can have substantial impact on the affected children and their families, as well as across systems including educational, medical, adult workforce, and juvenile justice. While there is increasing evidence of the validity of many psychiatric disorders in children down to the preschool age, developmental differences exist, both while comparing children and adults, as well as within the pediatric population. Similarly, there are important developmental differences in psychopharmacological treatment approaches and in the incidence of adverse effects. This course will provide an overview of recommended treatment approaches for non-child and adolescent psychiatrists. Specifically, the presentation will review the developmental differences in child psychopathology compared to adult psychopathology with particular attention to attention deficit hyperactivity disorder, disruptive behavior disorders, anxiety disorders, depression, disruptive mood dysregulation disorder, and bipolar disorder. The course will review first and second line treatment approaches, the relative strength of the evidence for these approaches with attention to the evidence supporting psychotherapeutic approaches, and clinical strategies for monitoring treatment effects and adverse effects.

Forums

Thursday, October 19, 2017

Current Mental Health Programs in the Military
Chairs: Elspeth Cameron Ritchie, M.D., M.P.H., Christopher H. Warner
Presenters: Dennis Sarmiento, M.D., Philip M. Yam, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand psychological reactions to serving in the military in the last 16 years of war; 2) Know about military programs to alleviate and treat psychological reactions to combat; 3) Learn the newest treatments for PTSD and depression related to war and re-integration with home; 4) Know the role of integrated and new treatments for PTSD; and 5) Learn how to decrease barriers to care for servicemembers.

SUMMARY:

The Long War began with 9/11. PTSD, traumatic brain injury (TBI), and suicide have emerged over the last 15 years of war as monumental issues for our servicemembers, veterans, and their families. About 2.7 million servicemembers have served in Iraq, Afghanistan, and other locations. About 15% of those who have been in combat have PTSD symptoms. During the wars in Afghanistan and Iraq, unanticipated and extended deployments were extremely taxing for military families. The U.S. military has developed many programs to prepare servicemembers for combat and to treat those with combat-related PTSD and depression. These will be described here in more detail. The wars are now winding down. Re-integration with home is a continuing problem with barriers to care and stigma. The rising suicide rate among servicemembers and veterans has been a major concern for all in the military. The combination of unit and individual risk factors for suicide include the high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability, alcohol, and easy access to weapons. Opioid addiction is a growing problem. Fortunately, there are emerging effective treatments for PTSD and TBI. Established evidence-based therapies are effective in most cases, but only if the servicemember completes the treatment. We have also learned clinical pearls for treating those with PTSD. Medication, psychotherapy, and alternative treatments are all helpful. While only two SSRIs (sertraline and paroxetine) are FDA approved, many others are commonly used. We have found bupropion especially useful. However, many servicemembers are noncompliant, either because they dislike the therapy or develop sexual side effects to medications. There are strategies to decrease the sexual side effects. Off-label use of medications can be very helpful for PTSD and TBI, including second-generation antipsychotics for PTSD and stimulants for TBI. Polypharmacy will likely be beneficial. Innovative, but not yet scientifically understood, approaches include acupuncture, stellate ganglion block, mindfulness, canine therapy, equine therapy, and others that help engage the patient. This forum will briefly describe psychological reactions to war and reintegration and emerging strategies for treatment. Important programs in the military will be outlined.

National Institutes of Health Town Hall: Hear From Leadership

Presenters: Wilson M. Compton, M.D., Robert Huebner, Ph.D., Robert Heinssen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify and understand priorities for drug abuse research, including how the shifting legal and policy environment regarding cannabis may impact psychiatric health and how psychiatry can play a role in addressing the opioid crisis; 2) Identify and understand priorities for mental health research, including new approaches for translating scientific findings into effective interventions that improve the treatment and prevention of serious mental illness; and 3) Identify and understand priorities for alcohol research, including a focus on heavy alcohol consumption by persons with co-occurring mental illnesses.

SUMMARY:

Improving mental health services depends on rigorous science which is often supported by the National Institutes of Health. Come meet leadership from the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) at this interactive town hall session with: NIDA Deputy Director Dr. Wilson Compton, NIMH Director of the Division of Services and Intervention Research Dr. Robert Heinssen, and NIAAA Acting Director of the Division of Treatment and Recovery Research Dr. Robert Huebner. Drs. Compton, Heinssen and Huebner will provide brief updates about their institute's scientific priorities as they relate to behavioral health, and the session will then include an open discussion with the audience. Science is moving forward quickly and making sure that the topics and issues of importance to you are addressed is key. Bring questions for the open discussion. NIH wants to hear from you!

Friday, October 20, 2017

SAMHSA Town Hall: Interdepartmental Serious

Mental Illness Coordinating Committee (ISMICC) Updates
Chair: Anita Everett, M.D.
Presenters: Justine J. Larson, M.D., David DeVoursney, M.P.P.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify and improve mental health disparities in; the community; 2) Demonstrate and apply new skills that will be useful in public psychiatry settings; 3) Examine how the current health care system affects patient care; 4) Describe how to transform systems of care; and 5) Recognize how to bring new innovations into a variety of treatments to improve patient care.

SUMMARY:
The ISMICC reports to Congress and federal agencies on issues related to serious mental illness (SMI) and serious emotional disturbance (SED). The ISMICC is composed of senior leaders from 10 federal agencies including HHS, the Departments of Justice, Labor, Veterans Affairs, Defense, Housing and Urban Development, Education, and the Social Security Administration along with 14 non-federal public members.

Supporting Medical Directors in Behavioral Health Clinics
Chair: Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe challenges faced by directors of behavioral health clinics.

SUMMARY:
This session is open to APA members who are active medical directors in behavioral health clinics. In a small group discussion with APA CEO and Medical Director Saul Levin, medical directors will have an opportunity to discuss challenges faced in the community setting and to brainstorm ways in which the APA might be able to assist. Topics for discussion include administrative and payment challenges faced in the FQHCs, challenges related to staff recruitment, contracting, workforce development, and leadership development.

Saturday, October 21, 2017

Addressing Barriers to Clozapine Underutilization: A National Effort
Presenters: Brian Hepburn, M.D., Raymond C. Love, Pharm.D., Deanna L. Kelly, Pharm.D.
Discussants: Andrew McLean, M.D., M.P.H., Frederick C. Nucifora Jr., D.O., Ph.D., M.H.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Discuss the utility of clozapine in the treatment of serious mental disorders; 2) List barriers to the use of clozapine; 3) Explain new guidelines and requirements for clozapine monitoring in the U.S., including the impact and recognition of benign ethnic neutropenia; and 4) Recognize national efforts to increase access to clozapine, including the development of a white paper and collaborative strategies to improve utilization.

SUMMARY:
Clozapine is the most effective antipsychotic for patients with treatment-resistant schizophrenia. Treatment guidelines recommend that a clozapine trial should be given to all eligible patients after failing two antipsychotic trials. Data on clozapine's cost effectiveness is growing as two recent publications tout significant costs savings. Clozapine can cause a variety of unique and serious side effects. The U.S. Food and Drug Administration (FDA) mandates registry-based monitoring of the absolute neutrophil count (ANC) for the duration of treatment with clozapine due to the risk of severe neutropenia. A host of potentially serious side effects requires a thorough consideration of both its risks and benefits, a thoughtful patient-centered approach, and a system that facilitates safe and appropriate use of clozapine. Risk-benefit discussions regarding the use of clozapine often ignore the psychiatric and medical risks of not using clozapine, such as the impact of inferior treatment on the patient's functioning, the medical risks from the use of higher than approved doses of antipsychotics, and the frequently employed practice of polypharmacy. Despite the overwhelming evidence of clozapine's superiority and its availability in generic form, clozapine is

prescribed infrequently in the U.S. compared to other countries. Recent Medicaid and pharmacy prescription data from all 50 states found that only six states used clozapine at a rate of 10% or higher. Other data suggest that many schizophrenia patients have at least three trials and inadequate treatment for years prior to clozapine initiation. Clinically and administratively, a wide variety of barriers to the use of clozapine exist, but few large-scale studies examine this issue. The barriers include provider, patient and family issues, resource availability, health system factors, and administrative burdens, while the recently introduced clozapine REMS system can present additional barriers to clozapine use and the recognition of less stringent monitoring requirements for those with benign ethnic neutropenia may help increase access. The National Association of State Mental Health Program Directors (NASMHPD) convened a national workgroup to identify barriers and make recommendations to improve clozapine use. This group of clinicians, researchers, and clinical administrators published a series of recommendations targeted at various groups with the power to increase access to and improve clozapine use. NASMHPD has begun efforts to reduce and address the barriers and implement selected recommendations to improve use and access to clozapine. This forum will focus on clozapine, its barriers, new monitoring issues, NASMHPD's efforts, and strategies to overcome underutilization and improve treatment with this evidence-based treatment.

Inside the APA Town Hall: A Discussion of Innovation Efforts to Improve Your Practice
Chairs: Anita Everett, M.D., Saul Levin, M.D., M.P.A. Presenters: Richard F. Summers, M.D., Philip Wang, M.D., Kristin Kroeger

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe initiatives within the APA that are designed to assist members address issues related to payment reform, physician well-being and burnout, and the PsychPRO registry.

SUMMARY:
This interactive session will provide members with an opportunity to engage members of the APA Leadership and APA Administration to discuss ways in which the APA can assist members in improving their practices, addressing administrative burdens, and addressing issues related to burnout and well-being. Building on Dr. Everett's theme of "Enhancing Access and Effective Care," panelists will discuss how the APA's PsychPRO registry can help meet quality reporting requirements, the efforts of the APA's Workgroup of Psychiatrist Well-Being and Burnout, and recent changes in payment reform that allow for the use of new collaborative care codes. Attendees will be encouraged to share concerns and provide feedback to panelists.

Learning Labs

Thursday, October 19, 2017

"Cloaks and Clergies": The Case of Patient B
Chair: Lawrence McGlynn, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Provide culturally competent care for diverse populations; 2) Integrate knowledge of current psychiatry into discussions with patients; and 3) Identify barriers to care, including health service delivery issues.

SUMMARY:
A highly interactive learning lab that will push attendees to use their medical and investigative skills to solve the complicated medical history of an anonymous patient. During this fun and engaging session, team up with fellow colleagues to solve clues, role play, brainstorm and interrogate characters from the patient's life, and put your sleuthing skills to the test in this mystery of Sherlock Holmes proportions. Each participant will work through a complex case and through the process of deduction determine the medical history of a real-life patient. You will learn and practice necessary critical thinking skills while diving deep into this gripping tale of medical mystery.

Friday, October 20, 2017

Innovation and Design Thinking in Mental Health

Care
Presenter: J. Andrew Chacko, M.D., M.S.E.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand what innovation and design thinking really are and what role they can play in the future of mental health care; 2) Understand some of the barriers to innovation in health care; and 3) Learn and practice some basic tools of design thinking and understand how it can greatly improve your patient engagement, transform your practice and reshape your personal life.

SUMMARY:
What is innovation? How is innovation in health care different? Why is it important for us as psychiatrists to understand? We will answer all those questions and more. The word innovation is so overused that it seems to have lost all meaning. And yet, if you are an outsider, it can feel quite daunting--something to do with technology and apps and interoperability. In this session, we will dig through all the misconceptions to arrive at what it really means. Simply put, innovation is a novel way to solve a problem. By first looking at other industries, we can delve into why innovation is critically important for us to understand and embrace. An inability to innovate and anticipate the future led to the collapse of titans of industry like Kodak and Blockbuster, while the opposite propelled young companies like Uber and AirBNB to the front of their respective packs. Interestingly, as physicians, we may feel secure in our field. Or are we? We will look at some of the companies/technologies that are driven by personal experience or lured by a piece of the $3.1 trillion U.S. health care pie. While we sit here, hundreds of software, hardware and app developers are trying to find better solutions to delivering mental health care that is more accessible, affordable and even fun for their clients. Even many of our patients, disgruntled with the state of mental health care, are out looking for "better" answers than we are providing. We will see how fellow clinicians--NPs, psychologists, pharmacists, social workers, MFTs--have already greatly modified our roles. So how do we navigate this new world? Better still, how do we master it? This highly interactive workshop will look at the fundamental reasons why innovation is particularly difficult in the health care space and will discuss design thinking as a process for innovation. Doctoring is very much like designing, and a better understanding of design can help us as we craft treatment plans and increase patient engagement. Among clinicians, as psychiatrists, we are particularly well suited for the first and possibly most critical step in design--to truly understand the problem--and that can put us at the helm, shaping the course not only of our discipline, but of medicine in general. We will learn and practice some of the same tools to enhance creative problem solving that the leading design firms in Silicon Valley use and apply them to problems we encounter in our practice. Innovative thinking can not only reshape your practice but can transform your personal life as well. And for a select few, whom these ideas ignite, it may radically alter your career.

Medical Director Boot Camp Day 1: Basics and the Medical Director as Educator
Chair: John Kern, M.D.
Presenters: Joseph Parks, M.D., Lori Raney, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe the unique role of the psychiatric medical director in mental health and medical organizations; 2) Understand the potential of the ECHO model to expand psychiatric expertise across under-supplied treatment organizations; and 3) Identify basic human resources functions required of a psychiatric medical director.

SUMMARY:
Join us on Friday and Saturday for a special Medical Directors' Boot Camp. Speakers from university medical programs, hospitals, and leadership training programs will offer an interactive way to learn the important aspects of what it means to be a psychiatric medical director who can function effectively as a leader. Participants will learn the basics of how to handle staff and subordinates, as well as higher-level strategies to expand the role and influence of the psychiatric medical director across the medical spectrum, and to address burnout in both the medical director and the psychiatric staff they supervise. A significant part of these sessions will also involve peer-to-peer networking, allowing

attendees to build their contacts to help them address the tricky issues that arise when you're the medical director in a bustling clinical setting.

Saturday, October 21, 2017

Medical Director Boot Camp Day 2: Special Populations and Sustainability
Chair: John Kern, M.D.
Presenters: Ruth Shim, M.D., M.P.H., Richard F. Summers, M.D., William Chandler Torrey, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify strategies to address the impact of the social determinants of mental health on their organizations and patients; 2) Discuss issues particular to psychiatric medical directors working in the VA system; and 3) Enumerate strategies to address burnout in themselves and in their medical staff members.

SUMMARY:
Join us on Friday and Saturday for a special Medical Directors' Boot Camp. Speakers from university medical programs, hospitals, and leadership training programs will offer an interactive way to learn the important aspects of what it means to be a psychiatric medical director who can function effectively as a leader. Participants will learn the basics of how to handle staff and subordinates, as well as higher-level strategies to expand the role and influence of the psychiatric medical director across the medical spectrum, and to address burnout in both the medical director and the psychiatric staff they supervise. A significant part of these sessions will also involve peer-to-peer networking, allowing attendees to build their contacts to help them address the tricky issues that arise when you're the medical director in a bustling clinical setting.

Lectures

Thursday, October 19, 2017

Hope Modules: Brief Psychotherapeutic Interventions to Counter Despair From Chronic Adversities
Chairs: John Peteet, M.D., Clark Aist, Ph.D.
Lecturer: James L. Griffith, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Distinguish demoralization as a normal syndrome of distress from depression and other psychiatric illnesses with low mood; 2) Conceptualize hope as a practice, i.e., “something you do” rather than “something you feel”; 3) Conduct an assessment of a person’s signature strengths for mobilizing hope; 4) Construct brief psychotherapeutic interventions that help a patient to mobilize hope when confronted by adversities; and 5) Engage patients’ spiritual resources as a source for hope practices that can be incorporated into brief psychotherapeutic interventions for mobilizing hope.

SUMMARY:
Despair from demoralization is a constant threat to patients with chronic mental illnesses, refugees fleeing persecution, elderly who are socially isolated, the medically disabled, and other marginalized or displaced people. These individuals often face pileups of acute and chronic stressors, including unsafe living conditions, loneliness, limited access to health care, and loss of social status or familiar identities. Demoralization refers to the helplessness and incompetence that people feel when sensing that they are failing to cope. The resulting despair produces avoidance and resignation when facing adversity, rather than assertive coping. Hope is a natural antidote for despair. However, hope can be ephemeral, or worsens despair, when life circumstances cannot be controlled. Hope modules are resilience-building psychotherapeutic interventions that strengthen morale by mobilizing a person's strengths for sustaining hope. Hope modules package skill sets for assessment, formulation, and intervention around a single evidence-based hope practice. Evidence-based hope practices were identified from psychological studies of resilient individuals and research literature of cognitive and social neuroscience, palliative care, psychosomatic medicine, and psychotherapy outcome studies. Hope modules address hope as a practice, rather than an emotional response to life circumstances, i.e., "something you do" rather than "something you feel." Hope as a practice can be

sustained despite ongoing stressors, emotional depletion, or numbness from trauma. Hope modules can be tailored to the specific predicaments with which a person is struggling. Assessment, formulation, and intervention are conducted by observing whether a person's immediate coping response to extreme stress best reflects strategies for individual problem solving and goal seeking (executive functions), relational coping (interpersonal social cognition), activating a core identity (social cognition of identity), or emotion regulation. This initial response points to the probable domain for signature strengths that can mobilize hope. The clinician then helps the person to intensify use or expand scope of similar hope practices from this domain. Hope modules fill a practice gap by providing psychotherapeutic interventions that help a person struggling against harsh or chronic adversities to sustain morale and avoid despair.

Zero Suicide in Health and Behavioral Healthcare: A Provider's Journey
Chair: Peter L. Chien, M.D.
Lecturers: Karen Rhea, Becky Stoll, L.C.S.W.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Emphasize extent to which a thoughtful, meaningful, and systematic Zero Suicide in Behavioral Healthcare approach saves lives for those at risk for suicide; 2) Describe the seven pillars and their components in the Zero Suicide in Behavioral Healthcare framework that can be used in different treatment settings; 3) Offer ways to build a suicide safer care model of suicide prevention to establish minimal standards for operating a system of care for individuals at risk of suicide; and 4) Share resources that exist to help providers and organizations improve their care management strategies for patients at risk for suicide.

SUMMARY:
The goal of this session is to highlight the Zero Suicide in Health and Behavioral Health Care framework which is being implemented across the United States in organizations such as emergency department (ED) providers, inpatient psychiatric settings, outpatient behavioral health care organizations, crisis services and primary care practices. The Zero Suicide framework's seven pillars (Lead, Train, Identify, Engage, Treat, Transition and Improve) establishes ways to operate within a care system that is safer for patients at risk for suicide, and thereby, to substantially reduce the number of suicide deaths and suicide attempts of those in care. The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an ED or inpatient psychiatric unit, yet as many as 70 percent of suicide attempt patients of all ages never attend their first outpatient appointment. Therefore, access to clinical interventions and continuity of care after discharge is critical for preventing suicide. It is imperative that various providers who engage with behavioral health patients work closely and that behavioral health systems of care weave comprehensive suicide prevention into the fabric of all aspects of operations. Speakers will describe the Zero Suicide in Health and Behavioral Health Care framework and give an example of it's implementation within a large outpatient behavioral health organization, their results/analytics related to suicide deaths in this organization and discuss how to overcome the barriers that exist to providing safer suicide prevention care.

Friday, October 20, 2017

Collaborating With the Cops: The Crisis Intervention Team (CIT) Model of Specialized Police Response to Persons With Mental Illnesses
Chair: Grayson Norquist, M.D., M.S.P.H.
Lecturer: Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe key elements of the Crisis Intervention Team (CIT) model; 2) Identify at least three key research findings on CIT; and 3) Understand the importance of CIT for facilitating access to appropriate psychiatric services.

SUMMARY:
The Crisis Intervention Team (CIT) model has become the leading form of law enforcement-mental health collaboration in the U.S. and has been implemented in numerous municipalities across the

country. Many police forces are seeking to train approximately 20% of officers using the 40-hour CIT curriculum; others are training all new recruits. The training, along with local reforms in both police and mental health policies and procedures, aims to improve officer and patient safety, enhance access to mental health services, and reduce unnecessary arrest and incarceration for minor infractions by people with serious mental illnesses. Given the enthusiasm for CIT from advocates, law enforcement and other public safety personnel, and mental health professionals—and in light of the increasing pace of implementation of this complex collaboration in a multitude of localities across the country—this lecture provides an overview of the program and recent research findings. In one of Dr. Compton's large studies, 251 CIT-trained officers had consistently better scores on knowledge, diverse attitudes toward mental illnesses and their treatments, self-efficacy for interacting with someone with psychosis or suicidality, social distance stigma, de-escalation skills, and referral decisions compared to 335 non-CIT officers. Effect sizes for some, including de-escalation skills and referral decisions pertaining to psychosis, were substantial (d=0.71 and 0.57, respectively, both p<0.001). In another of Dr. Compton's studies involving 1,063 encounters, CIT-trained officers were significantly more likely to report "verbally engaged, negotiated with the subject" as the highest level of "force" used. Referral to services or transport to a treatment facility was more likely (OR=1.70, p=0.026) and arrest less likely (OR=0.47, p=0.007) when encounters involved CIT-trained officers compared to non-CIT officers; moreover, these findings were most pronounced when force was necessary. Two other studies examining models explaining how CIT training might achieve these results will also be reviewed. Although findings are accumulating, additional research on this rapidly expanding collaborative service model is of utmost importance. CIT is an important avenue for collaboration between community psychiatrists, health services researchers, advocates, and law enforcement and other public safety professionals.

Physicians' Work to Reverse the Nation's Opioid Epidemic

Chair: Michael T. Compton, M.D., M.P.H.

Lecturer: Patrice A. Harris, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explain the role of the AMA Opioid Task Force; 2) Identify the actions that physicians can take to reverse the nation's opioid epidemic; 3) Discuss the data demonstrating physicians' work to reverse the epidemic; and 4) Highlight areas that must still be addressed to ensure access to treatment for patients.

SUMMARY:

The American Medical Association (AMA) Opioid Task Force formed in 2014 to coordinate the efforts of the nation's medical societies to combat the growing opioid misuse, overdose, and death epidemic. The task force includes the AMA and more than 25 state, national, and specialty medical societies, including the American Psychiatric Association. The task force recognized that many physician organizations were taking action to help educate physicians about the growing epidemic, but there was a need to combine efforts and amplify the voice of organized medicine and physician leadership. In 2015, the task force issued five recommendations: 1) Encourage physicians to use prescription drug monitoring programs (PDMPs); 2) Enhance education to help ensure the most appropriate prescribing decisions; 3) End the stigma of pain and support comprehensive pain care, including non-opioid and nonpharmacological treatment(s); 4) End the stigma of substance use disorders and increase access to comprehensive treatment, including mental and behavioral health care; and 5) Increase access to naloxone and broad good Samaritan laws to help save lives from overdose. In 2017, the task force issued a new recommendation to urge physicians to talk to their patients about safe storage and disposal of opioids and all medications to reduce the risks associated with unwanted, unused, and expired medications. Legislatures have also enacted many new laws and other requirements to regulate physician behavior. These include new mandates to use PDMPs and new restrictions on opioid prescribing. Access to naloxone has also greatly expanded. With only a few exceptions, there has been little action on increasing access to treatment, although passage of the federal

Comprehensive Addiction and Recovery Act and subsequent funding may help. As state laws and national attention have increased commensurate with growing opioid-related overdose and mortality, it is critical to review the data. Generally, physician efforts began prior to enactment of the new laws mandating physician actions. This includes increases in PDMP use, decreases in opioid prescriptions, and increases in lives saved through naloxone. The data also show a large increase in physicians trained to provide in-office buprenorphine for the treatment of substance use disorders, but it is unclear whether private and public payer policies have changed to truly allow for patients to access care. There is great concern about the changing nature of the epidemic and the growing mortality rates due to heroin and illicit fentanyl. There are also increasing concerns about patients losing access to care, as physicians and other health care professionals may no longer be providing pain care due to fear and other concerns. To reverse the epidemic, physician leadership must continue, and considerable attention must be focused on ensuring access to comprehensive pain care and patient access to treatment for substance use disorders.

Psychiatry's Role in Addressing the Physical Health Status of Patients With Serious Mental Illness
Chair: Alvaro Camacho, M.D., M.P.H.
Lecturer: Benjamin G. Druss, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand the burden of poor physical health and early mortality among patients with serious mental illness; 2) Understand the behavioral, health care, and social factors contributing to poor physical health and early mortality among patients with serious mental illness; 3) Identify evidence-based approaches to addressing poor physical health and early mortality among patients with serious mental illness; and 4) Identify emerging roles for psychiatrists in addressing poor physical health and early mortality among patients with serious mental illness.

SUMMARY:
This lecture will discuss clinical, research, and policy developments in addressing poor physical health and early mortality for patients with serious mental illness.

Saturday, October 21, 2017

Impact of Trauma: From Molecules to Communities
Chair: Michael Flaum, M.D.
Lecturer: Kerry Ressler, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe new research across patient populations and animal models in the neurobiology of PTSD; 2) Discuss the impact of poverty, cycles of violence, and trauma exposure on risk for civilian PTSD; and 3) Educate others on potential new treatment methods, as well as further understanding current approaches to treating PTSD.

SUMMARY:
Exposure to traumatic events during development has consistently been shown to produce long-lasting alterations in the hypothalamic-pituitary-adrenal (HPA) axis and other stress pathways. Furthermore, substantial data document high levels of childhood and adult trauma exposure, principally interpersonal violence, among impoverished, urban communities. Within this population, the level of ongoing stress increases vulnerability to disease, including posttraumatic stress disorder and other mood and anxiety disorders. Data suggest that molecular pathways regulate stress function in conjunction with exposure to child maltreatment or abuse. In addition, a large and growing body of preclinical research suggests that increased activity of the amygdala-HPA axis induced by experimental manipulation of the amygdala mimics several of the physiological and behavioral symptoms of stress-related psychiatric illness in humans. These translational findings lead to an integrated hypothesis: high levels of early life trauma lead to disease through the developmental interaction of genetic variants with neural circuits that regulate emotion, together mediating risk and resilience in adults. This lecture will review the effects of trauma on molecular systems to neural circuits and how this impacts communities devastated by high levels of trauma and violence.

Psychiatric Services **Achievement Award Winners: Innovation in Service Delivery**

No. 1

APA Gold Award: Service Program for Older People (SPOP) and Strategies to Increase Access to Mental Health Care for Older Adults

Lecturer: Nancy Harvey, L.M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify strategies for service delivery to community-dwelling older adults; 2) Identify effective partnerships to increase access to mental health care; and 3) Identify strategies to reduce stigma associated with mental illness in a geriatric population.

SUMMARY:

Older adults are at increased risk for developing behavioral health disorders, often due to physical decline, loss of a loved one, or social isolation. Community-dwelling older adults present a challenge to the mental health professional, as they are often difficult to identify and/or are reluctant to seek treatment. Service Program for Older People (SPOP) has developed strategies to identify at-risk seniors, provide information, reduce stigma, and deliver service either in the home or at a neighborhood senior center. Working with medical providers, social service agencies, government entities, and senior centers, SPOP has successfully reduced hospitalization rates, increased social connectedness, and improved overall well-being for this population. This presentation will review how SPOP developed partnerships with Mount Sinai Visiting Doctors, the New York City Department for the Aging, SAGE/Services and Advocacy for GLBT Elders, and other organizations to meet the need for community-based geriatric mental health care.

No. 2

CAP PC: New York State's Multi-University Education and Collaborative Care Child Psychiatry Access Program

Lecturer: David L. Kaye, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe different models of integrated care; 2) Describe the rationale for child psychiatry access programs; and 3) Describe the structure, evolution, and results of CAP PC, a large scale child psychiatry access program in New York state.

SUMMARY:

Objective: Although child mental health problems are widespread, few get adequate treatment, and there is a severe shortage of child psychiatrists. To address this public health need many states have adopted collaborative care programs to assist primary care to better assess and manage pediatric mental health concerns. This report adds to the small literature on collaborative care programs and describes one large program that covers most of New York state Methods: CAP PC, a component program of New York State's Office of Mental Health (OMH) Project TEACH, has provided education and consultation support to primary care providers in 90% of New York state since 2010. The program is uniquely a five medical school collaboration with hubs at each that share one toll free number and work together to provide education and consultation support services to PCPs. Results: CAP PC has grown over the 7 years of the program and has provided 8957 phone consultations to over 1600 PC Ps. The program synergistically provided 18,038 CME credits of educational programming to 1200 PCPs. PCP users of the program report very high levels of satisfaction and self reported growth in confidence. Conclusions: CAP PC demonstrates that large-scale collaborative consultation models for primary care are feasible to implement, popular with PCPs, and can be sustained. The program supports increased access to child mental health services in primary care and provides child psychiatric expertise for patients who would otherwise have none.

No. 3

Improving Access to Treatment for Perinatal Mental Health and Substance Use Disorders: A Look at MCPAP for Moms

Lecturer: Nancy Byatt, D.O, M.B.A., M.S.
Co-Authors: Tiffany A. Moore-Simas, John H. Straus

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide background information on the public health relevance of perinatal depression, particularly to obstetric providers; 2) Describe the development, implementation and outcomes of a low-cost population based program to address perinatal depression, the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms); and 3) Discuss how the MCPAP for Moms model can be leveraged to increase access to perinatal psychiatric care in other states.

SUMMARY:

Despite routine contact with medical care through obstetrical providers, the majority of women with perinatal depression do not receive treatment due to multi-level barriers. Screening for perinatal depression alone does not improve treatment rates or patient outcomes. Addressing the multi-level barriers to treatment will ultimately require a practical and sustainable platform. In this session, we will describe a statewide program, the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms), that addresses this major public health need by providing: 1) trainings and toolkits for providers on evidence-based guidelines for screening, assessment and treatment or perinatal mental health and substance use disorders; 2) access to real-time telephonic psychiatric consultation for providers serving pregnant and postpartum women; and, 3) care coordination. Since its launch in July 2014, MCPAP for Moms has enrolled 122 Ob/Gyn practices accounting for >80% of deliveries in the state, conducted 133 trainings, provided 2,696 care coordination activities and 1,690 phone consultations, serving 2,383 perinatal women. The total cost of the program, including administrative expenses, is $11.81 per perinatal woman per year ($0.98 per month) or $850,000 for 72,000 deliveries annually in Massachusetts. The presentation will discuss sustainability including Massachusetts surcharge on commercial insurers. MCPAP for Moms led to the recently passed federal HR. 3235, Bringing Postpartum Depression Out of the Shadows Act of 2015 (consolidated in the 21st Century Cures Act), which will appropriate $25,000,000 over 5 years to establish MCPAP for Moms-type programs. In this presentation, we will set the context for the development of MCPAP for Moms, describe the process of implementation, and present the first three years of program utilization data. We will review lessons learned during implementation of MCPAP for Moms, future directions, and how it can serve as a model for other states.

No. 4

Closing the Early Psychosis Treatment Gap and Preventing Disability

Lecturer: Jean-Marie Bradford, M.D.
Presenter: Nannan Liu, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learners will understand the concept of coordinated specialty care (CSC); 2) Learners will understand the core components of the OnTrackNY/WHCS CSC model for treatment of early psychosis; 3) Learners will be understand three evidence based practices that can be implemented treatment of individuals with early psychotic symptoms; and 4) Learners will be able to describe three resources to help implement evidence based practices and CSC models for early psychosis.

SUMMARY:

Approximately 100,000 adolescents and young adults in the US experience first episode psychosis (FEP) each year. There is a growing effort to decrease the often long delays between onset of psychotic symptoms and initiation of treatment in order to reduce the burden of illness. The OnTrackNY model for treatment of first episode psychosis was created by a team led by Lisa Dixon, MD, and grew out of the NIMH-funded research study, Recovery after Initial Schizophrenia Episode (RAISE). Embedded in the Washington Heights Community Service (WHCS) at New York State Psychiatric Institute, OnTrackNY/WHCS began in October 2013 and was one of four initial sites for the OnTrackNY model. OnTrackNY/WHCS is an innovative, multidisciplinary team approach to providing recovery oriented treatment to young people aged 16-30 who are within two years of first experiencing psychotic symptoms. OnTrackNY/WHCS is a Coordinated Specialty Care (CSC) model, which provides a package of specific services to treat early

psychosis, emphasizing evidence-based treatments in a team based format for two years. Components of the CSC model include medication management, supported employment and education, cognitive and behaviorally based relapse prevention, illness management, integrated substance abuse treatment, case management, suicide prevention, and family intervention and support. Services are provided in individual and group formats according to consumers' preferences. OnTrackNY/WHCS has achieved measurable success in multiple quality measures. OnTrackNY/WHCS has proven to be effective at helping participants improve quality of life and achieve educational and occupational goals, doubling rates of work or school enrollment from 40% to 84% at one year of treatment. Efforts to engage patients and families have proven to be successful, visiting all participants in the community at least once, maintaining engagement and providing family support to over 85% of participants. Through this high engagement, we have been able to decrease emergency room (ER) utilization from 80% of participants with one or more ER visits on admission to the program to 14% over the course of treatment. We have also been able to decrease inpatient hospitalization rates from 66% of participants with one or more hospitalizations to 10% over the course of treatment.

State Public Mental Health Systems: Past, Present, and Future

Chair: Ruth Shim, M.D., M.P.H.
Lecturer: Ann Marie T. Sullivan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Gain knowledge of the history of State Public Mental Health Systems and their transition to the current philosophy of integrated, community-based care and inclusion; 2) Gain knowledge of the best practices in an integrated continuum of community care, including hospital-based care when needed, that have enabled individuals to live full and productive lives in the community, with some focus on initiatives in New York State; 3) Be engaged in a discussion of the continuing challenges in the transition to community-based care, especially the challenges facing individuals living with serious mental illness who are homeless, or have been involved in the criminal justice system; and 4) Understand best practices, as well as the systems barriers that exist and need to be addressed.

SUMMARY:

For over 60 years, State Public Mental Health Systems across the nation have been transitioning from inpatient institutional care for individuals with serious mental illness to community-based care focused on recovery and successful integration into community life. While the media discussions often focus on the reduction of inpatient psychiatric beds in what were former large institutions, these discussions have missed the story of significant investments in community based care and recovery that have enabled so many individuals with serious mental illness to live successful lives in the community. We are in a time when best practices in making community based care successful are well known, but unfortunately not always financed or implemented to the extent needed. While there has been significant progress, we are still faced with serious challenges in providing a robust continuum of care that can also meet the needs of individuals with serious mental illness who are involved with the criminal justice system or who are homeless and disconnected from community. We are also challenged to ensure that the services we provide truly integrate care for the whole individual, including behavioral health and physical health. Furthermore, early intervention and prevention of serious mental illness need to be infused in our systems of care. This lecture will focus on the successes as well as the challenges faced by State Public Mental Health Systems, and discuss models of service that in the future could provide a continuum of care for individuals where hospital beds are available when needed, followed by successful transitions to care and inclusion in the community.

Update on Electroconvulsive Therapy (ECT)

Chair: Robert Osterman Cotes, M.D.
Lecturer: Charles H. Kellner, M.D.
Presenters: Robert M. Greenberg, M.D., Adriana Hermida, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Understand the clinical indications for ECT; 2) Discuss with patients the likely adverse effects of ECT and how to manage them; and 3) Understand the ongoing role of stigma in the underutilization of ECT.

SUMMARY:
Electroconvulsive therapy (ECT) remains an indispensable treatment in modern psychiatric medicine. For treatment-resistant depression and a limited number of other severe psychiatric illnesses, it is the most effective and rapidly acting therapeutic modality. Advances in ECT technique have made the treatment even safer and better tolerated than in the past. Stigma and lack of familiarity with contemporary ECT techniques are the most significant barriers to the appropriate prescription of ECT in the U.S. and around the world today. In this lecture, the speakers will provide an overview of ECT, with a review of clinical indications and an update on modern ECT technique. Data from recent ECT clinical trials will be presented. The logistics of a course of ECT and the clinical decision making during the course of treatment will be discussed in detail. Common treatment-emergent adverse effects and their management will be covered, so that the referring practitioner will gain the knowledge needed to support their patient during the course of ECT. The problem of the stigma surrounding ECT will be discussed, along with suggestions for overcoming and combating it. Ample time will be allowed for questions and audience participation.

Sunday, October 22, 2017

Forensic Child and Adolescent Psychiatry: Contemporary Issues
Lecturer: Elissa P. Benedek, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Review child forensic psychiatry in the past; 2) Review present controversies and issues in child forensic psychiatry; and 3) Peek into predictions about the future of child and adolescent forensic psychiatry.

SUMMARY:
Forensic psychiatry is the subspecialty of psychiatry that focuses on the interface between psychiatry and the law. It may involve the evaluation of individuals involved in the legal system, working in juvenile correction facilities, involved in legal issues related to practice teaching, and performing research. Traditionally, child and adolescent forensic psychiatry has focused on issues of child abuse, neglect, custody, and delinquency. Beginning in the early 1980s, many child and adolescent psychiatrists were drawn into civil suits as expert witnesses in child custody cases during divorce proceedings and cases alleging child sexual abuse. Civil litigation involving youth has expanded, including suits for psychic trauma, malpractice, and class action suits against institutions for neglect and abuse. The evaluations done for the criminal courts have also changed. Competency examination evaluations have changed so that it is now important to consider the developmental age of the juvenile in the assessment. Most importantly for youth tried as adults, forensic evaluations are increasingly utilized in sentencing decisions. Two important decisions, Roper v. Simmons (2005) and Grahm v. Florida, have supported the understanding of why adolescents think and behave differently than adults. In particular, in Grahm, the Court held that a sentence of life without parole (LWOP) was unconstitutional for all non-homicide offenders. Two years after Grahm, in 2012, the Court ruled that, even for murder, a mandatory LWOP sentence for adolescents was unconstitutional. This has led to reevaluations of many juveniles. The future holds promise for increased use of developmental information in rehabilitating adolescent offenders. In addition, because of the increased frequency of divorce and the change in family structures, the standards for determining child custody and visitation will need to be reviewed and updated to preserve the doctrine of “best interests of the child.”

Measuring Behavioral Health Quality and Performance: When and Why Does It Matter?
Chair: Erik R. Vanderlip, M.D., M.P.H.
Lecturer: Thomas Smith, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand current performance measurement programs used by

payers and providers; 2) Become familiar with commonly used performance measures and the processes by which measures are developed; and 3) Understand current controversies in performance measurement as well as efforts underway to develop measures of patient-centered and functional outcomes related to health care.

SUMMARY:
The focus on value- and person-centered outcomes in health care is increasing dramatically, best exemplified by the U.S. Department of Health and Human Service's goal of tying 85% of all Medicare fee-for-service payments to quality or value by 2016 and 90% by 2018. This shift has stimulated efforts to develop and implement meaningful health care performance measurement strategies. Behavioral health (BH) has lagged behind general medicine in the development of performance measures, but recent studies indicate that effective management of BH conditions will be critical to improve health care value across the spectrum of illnesses and treatment settings. Stakeholders (regulators, payers, and practitioners, including psychiatrists) therefore must address important questions about when and what elements of BH care can and should be measured to support quality improvement and value-based payment initiatives. This lecture will describe current measurement programs targeting managed care organizations, provider networks (including accountable care organizations), and individual practitioners, including psychiatrists. We will review how a measure is "born" (e.g., the screening and evaluation procedures that lead to measure endorsement) and will discuss specific measures commonly used by providers, managed care organizations, and payers, including Medicare and Medicaid. Current controversies will be reviewed, such as the relative merits of measuring processes versus outcomes, how to measure quality of care related to low-frequency outcomes such as suicide and violence, and the need to limit burden on providers and payers related to multiple overlapping measures and accountability programs. Particularly relevant to BH providers, including psychiatrists, is the field's lack of tested measures of functioning, social connectedness, recovery from chronic illness, and patient-reported outcomes related to perception of and involvement in care. We will finish with a survey of the emerging services research literature examining the impact of performance measurement programs on health care outcomes as well as a summary of future directions related to measure development and use in alternative payment models.

White Opioids: Lessons on Race from the Overdose Crisis
Chair: Marc Manseau, M.D., M.P.H.
Lecturer: Helena B. Hansen, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Participants will be able to name three factors leading to the current racial demographics of opioid use and overdose; 2) Participants will be able to articulate the role of racial symbolism in shaping drug policy, regulation and marketing; and 3) Participants will be able to describe at least two policy interventions that promise to rectify the racial inequalities and overall overdose fatalities stemming from current clinical practice.

SUMMARY:
The current opioid overdose crisis and its focus in white suburban and rural communities raises questions about race, drug policy, and addiction medicine in the U.S. This lecture draws on extensive research among pharmaceutical executives, addiction researchers, drug policy makers, prescribing physicians and patients to reconstruct the role of race in addiction neuroscience, biotechnology development, drug regulation and marketing, as well as their role in shaping current demographic patterns of opioid use and the shifting cultural symbolism of narcotics. Using critical race theory, analysis of in-depth interviews with key participants in opioid policy and practice, media coverage of race and opioids, as well as secondary analysis of epidemiological trends, the lecture concludes with counterintuitive conclusions about the harms of racialized market segmentation to white as well as non-white patients, and recommendations a a re-examination of the tension between our commodified health care system and public health oriented clinical practice.

Presentation of Award-Winning Documentary *God Knows Where I Am*
Chairs: Todd Wider, M.D., Jedd Wider

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand more clearly the systemic failures that lead to negative outcomes for people with severe mental illness; 2) Understand more clearly the pivotal role care providers, law enforcement, and courts can play in patient outcomes; and 3) Discuss meaningfully the reasons for possible legal changes to existing laws affecting patients' civil rights.

SUMMARY:
This media workshop will feature presentation of the documentary *God Knows Where I Am* (runtime 97 minutes), followed by Q&A with the filmmakers (15 minutes). The body of a homeless woman is found in an abandoned New Hampshire farmhouse. Beside her lies a diary that documents a journey of starvation and the loss of sanity, but told with poignancy, beauty, humor, and spirituality. For nearly four months, Linda Bishop, a prisoner of her own mind, survived on apples and rain water, waiting for God to save her, during one of the coldest winters on record. As her story unfolds from different perspectives, including her own, we learn about our systemic failure to protect those who cannot protect themselves. A response to the film by a prominent APA member, Paul S. Appelbaum, M. D., Dollard Professor of Psychiatry, Medicine, and Law at Columbia University, says "*God Knows Where I Am*—beautiful, haunting and supremely moving—is one of the most powerful documentary films I have seen on America's flawed approach to mental health and homelessness. Essential viewing for anyone seeking to understand the systemic failings of our mental health care system, it is at once a work of art and a clarion call to end our neglect of people with mental illnesses. The film powerfully conveys how an empty commitment to individual liberty has been substituted for a genuine system of mental health treatment and leaves us with one unavoidable conclusion: we can and must do better." Presented by the filmmakers themselves, this highly acclaimed documentary has been the catalyst for discussions among the legal and legislative communities as well as the psychiatric profession. It provides an unvarnished and unsentimental yet compassionate view of its subject, her family, and others who were unable to prevent her death. Context within the film is provided through interviews with prominent psychiatrists and other nationally recognized experts. Emblematic of the institutional perils faced by the severely mentally ill, *God Knows Where I Am* is a communications tool for educators and treatment professionals to explore and illuminate these issues. In an era of uncertainty for the future of health care, this film helps to clarify and prioritize issues of vital importance.

Poster Sessions

Thursday, October 19, 2017

Poster Session 1

No. 1
Mail-Order Nootropics: A Case of Tianeptine and Phenibut Abuse and Withdrawal
Poster Presenter: Rachel Hammer, M.D., M.F.A.

SUMMARY:
Case Description A 25-year-old man from Lebanon with a past psychiatric of opioid use disorder, PTSD, major depression refractory to multiple trials of SSRIs and recent suicide attempt by hanging self-presented to our ED with suicidal ideation. The patient reported that he had been self-medicating with tianeptine and phenibut; both medications were purchased online. Fear of opioid-withdrawal symptoms contributed to his suicidality. He reported using 4 grams of tianeptine five times daily, and 3 grams daily of phenibut, which cost approximately $500/week. On admission, his blood pressure was 159/92 with tachycardia. Urine drug screen was negative (of note, our lab does not assay for the substances he claimed to have used, but the patient did bring in bottles of the product to review). On initial exam, he was oriented, appeared dysphoric and had linear thought processes with no hallucinations. His initial CIWA-AR score was 3. He was given clonidine and chlordiazepoxide on the second hospital day for CIWA-AR score of 10. The next day he had an abrupt and marked change in

status. He developed chills, tactile hallucinations, nausea, diarrhea, abdominal pain, and piloerection. Over several hours, his mental status deteriorated; he became disoriented and developed distressing visual hallucinations. On transfer to our ICU for autonomic instability in the setting of severe withdrawal, his CIWA-AR was 33. In the ICU, he was intubated and his vitals stabilized on valium and dexmedetomidine drips, from which he had difficulty getting weaned over five days. Discussion Nootropics including tianeptine and phenibut are increasingly recognized as drugs of abuse in the United States. Nootropics is a new term for "smart drugs," an emerging class of cognitive-enhancing medications. Tianeptine is a TCA-like and "serotonergic enhancing" medication prescribed commonly in the Middle East and Europe for depression and anxiety. Euphoria has been noted at doses greater than 100 mg (usual maximum daily dose is 50 mg). Tianeptine has weak mu-opioid receptor binding at high doses, and in rats, increases dopamine in the nucleus accumbens. Little is known about tianeptine withdrawal. Phenibut is a GABA-B receptor agonist and case reports bear resemblance to benzodiazepine intoxication and withdrawal and should be regarded as life-threatening. Neither tianeptine nor phenibut are FDA-approved for use in the United States. Urine drug screens do not commonly assay for these substances. Without standardized literature with reliable pharmacodynamics, it is difficult to safely anticipate and manage withdrawal symptoms, and given the severity reported in case reports, we recommend that patients reporting high dose tianeptine and/or phenibut use be monitored for withdrawal in an ICU setting. Conclusion Tianeptine and phenibut are both psychoactive substances available to the public without a prescription and both have dangerous and potentially fatal withdrawal syndromes.

No. 2

Getting Better Together: Using Lean Methodology to Develop a Quality Improvement Experience at an Inner City Hospital

Poster Presenter: Farah Herbert, M.D.
Co-Authors: Renuka Ananthamoorthy, M.D., Christine Pyo, Donna Leno-Gordon, R.N., Jennifer Morrison-Diallo, Ph.D.

SUMMARY:
As the expectations for hospital reimbursement shift to include measures of the quality of care delivered through various metrics, including patient satisfaction, clinicians and administrators must review and adapt the framework for delivering care. In mental health this involves recognizing some of the unique experiences that influence patients and color their hospital experience as well as attempting to mitigate how being maintained in a restricted facility, often against their will, is handled. While exploring strategies to improve the Patient Experience by developing strategies to listen and respond to patient concerns in real-time, it became evident that past traumas played a significant role in shaping the view of the hospital experience. While learning how to develop a Trauma-Informed Care Setting it was evident that how moments of crisis are contained not only defined the experience of the patient but was heavily influenced by staff perceptions of safety and support and their ability to provide empathetic responses while preventing harm. Our interdisciplinary team examined the factors which contributed to improving patient satisfaction then realized a novel, integrated approach was needed to improve patient and staff experience. The Getting Better Together initiative includes four components: a) Patient Experience, b) Staff Wellness, c) Zero Assaults, and d) Trauma-Informed Care. The team identified and implemented myriad brief interventions for monitoring and addressing concerns throughout the admission to form the Patient Experience Initiative. A staff training initiative in trauma was instituted with changes to the treatment milieu reflecting recognition of trauma triggers and planning care to consider this in order to develop a Trauma-Informed Milieu. Annual training in preventing and managing crisis situations was augmented by a vision to achieve Zero Assaults by providing regular practice situations in which unit teams utilized each other, their skills and knowledge of an identified patient in impending crisis to de-escalate the situation. While education for staff in these techniques is important, preventing burnout and fostering strong teams that share the institutional vision is critical to developing a sustained culture change. Wellness Programs were prioritized and expanded to address staff morale and satisfaction. Follow-up data on the effects of this

initiative has shown the following: a) Small but sustained gains in patient satisfaction scores measured by Press Ganey, b) Decrease in staff burnout, compassion fatigue and improvements in staff perception of workplace support and self-care through internal survey, c) Strong inverse correlation between frequency of psychiatric code simulations and injury and assaults, and d) Decrease codes and readmissions for high-profile traumatized clients and qualitative data shows a shift in staff perceptions regarding the source of distressing behaviors.

No. 3

Impulsivity and Its Role on the Relationship Between Binge Eating and Compulsive Buying

Poster Presenter: Cristiana Nicoli de Mattos, M.D.
Co-Authors: Hyoun S. Kim, David C. Hodgins, Hermano Tavares

SUMMARY:

Compulsive buying disorder is commonly found worldwide and is characterized by excessive shopping, which results in distress and impairments (e.g., financial). Much like other psychiatric disorders, co-morbidity in compulsive buying disorder is the rule, rather than the exception. Particularly, the literature suggests that binge eating frequently co-occurs in patients with compulsive buying disorder. However, the mechanism by which compulsive buying and binge eating are related is unknown. Herein, we present the results of assessing whether hoarding behaviors mediate the relationship between compulsive buying and binge eating in a large clinical sample (N=210) of compulsive buyers seeking treatment in São Paulo, Brazil. We hypothesized that the relationship between compulsive buying and eating disorder would be mediated by the psychological need to excessively gather and store items, be it food or items (i.e., hoarding). To this end, patients voluntarily seeking treatment for their compulsive buying underwent a semi-structured clinical interview (The MINI) by a registered psychiatrist to make diagnoses of psychiatric disorders, including compulsive buying. Thereafter, they completed a battery of measures to assess the severity of compulsive buying (Compulsive Buying Disorders Scale), binge eating (Binge Eating Scale) and hoarding (Saving Inventory Revised). The hypothesized mediation model was tested using Preacher and Hayes (2013) Process Macro to obtain biased corrected 95% CI intervals with 5000 iterations. The results found that compulsive buying severity was not a significant predictor of binge eating. However, recent advances have found that a significant direct relationship is not needed when proposing a significant indirect effect. Indeed, our results found that the relationship between compulsive buying and hoarding was significantly mediated by hoarding 95% CI [-.71, -.0002]. Our results suggest that the need to excessively gather and store items may be a transdiagnostic process that is important in understanding behaviors characterized by excessive consumption. Further, treatments that target the underlying psychological need to hoard items may be an effective treatment for both compulsive buying and binge eating.

No. 4

Suboxone-Induced Bilateral Lower Extremity Edema: Two Case Reports and Literature Review

Poster Presenter: Shivanshu Shrivastava, M.D.
Co-Author: Ye-Ming Sun

SUMMARY:

Background and Objective - Suboxone has been widely used for opioid detoxification and opioid replacement therapy. Most common side effects of Suboxone are nausea, vomiting, back pain, dizziness, flushing and headache. Very little has been discussed in literature about Suboxone leading to peripheral edema. Here we report two cases of Suboxone induced edema bilaterally in the lower extremity. Methods and Results - The first case was a 44 year old African American male with a diagnosis of Schizoaffective Disorder. He was on Suboxone for about a year for opioid replacement therapy. During his 3rd admission for psychosis, he started complaining of bilateral leg pain (1-2 out of 10 on the pain scale) followed by edema. Cardiac workup and venous doppler did not show any abnormality. He benefited a little from the compression stockings. We reduced his Suboxone from 8mg-2mg TID to 2mg-0.5 mg BID and then the edema resolved. In the second case, the patient was a 37 year old Caucasian female with a diagnosis of Bipolar Disorder. She was status post below knee amputation and was on Percocet for pain at home. She was started on

Suboxone to replace her Percocet. Within two days of starting Suboxone 4mg-1mg BID she complained of bilateral lower extremity edema. Cardiac workup, venous and arterial doppler did not show any abnormality. Complete resolution of edema was noted after discontinuation of Suboxone. Discussion and Conclusion - There have been reports of peripheral edema with Suboxone use however any precise data is not available. Website www.ehealthme.com refers to self reported 267 cases of peripheral edema out of the 6171 Suboxone users. The exact mechanism leading to edema remains unknown. There are multiple causes of peripheral edema. Mast cell activation with release of histamine and tryptase has been proposed as a possible mechanism. Another suggested hypothesis is increased vasopressin release from posterior pituitary. The pattern of clinical presentation is not well described. From these two cases we learn that the peripheral edema due to Suboxone is reversible. After reducing the dose in the first case and stopping Suboxone in the second case, the peripheral edema resolved completely. We also learn that peripheral edema due to Suboxone is dose dependent as seen with the first case. Thus for patient's who cannot be taken off of Suboxone completely, reducing the dose may help. Suboxone can lead to peripheral edema after chronic use as well as in acute use as shown by these two cases.

No. 5

Telepsychiatry Webcam Screen Display Preferences in Individuals With Down Syndrome or Autism in a Community Mental Health Center

Poster Presenter: Nita V. Bhatt, M.D., M.P.H.
Co-Authors: Julie P. Gentile, M.D., Allison E. Cowan, Randon Welton

SUMMARY:
Hear from some of the prime architects and clinicians of a thriving Intellectual and Developmental Disability Division that is committed to fostering innovation and using technology to provide cutting edge services to patients with ID/DD in under-served areas. Ohio's Telepsychiatry Project began in 2012 to provide specialized services to individuals with co-occurring mental illness and intellectual disability with the most complex needs living in outlying areas that lack the infrastructure and resources to offer the highest quality care. Currently, over 800 patients with IDD from 58 counties receive mental health treatment through this statewide grant-funded project. The project fosters innovation and the use of HIPAA protected software for the provision of the highest quality mental health care to individuals in the state with the most complex needs. The profound impact of this program led the Psychiatry Residency to create a specialized ID/DD track for its residents. The Division's operations, funding structure, resident training curriculum and specialty residency track will all be discussed. Here's a preview of the outcomes: • For individuals engaged in the program, emergency room visits decreased 96% and hospitalizations decreased 86%. • More than 90 individuals were discharged from state operated institutions and none were readmitted for long term stay saving the state $80,000/person/year. • Travel costs were reduced up to 68% by not having to travel distances for specialty psychiatric care. Individuals with ID experience mental illness at rates higher than that of the general population. There is a lack of physicians with training in ID psychiatry, especially in under-served communities. This statewide grant funded program prioritizes patients discharged from state psychiatric hospitals, developmental centers, and those with multiple emergency department visits/hospitalizations due to behavior issues, mental illness, and complex medical needs. The lack of appropriate care severely impacts the quality of life for patients with ID in rural areas while also inflating the cost of care due to increased staffing needs, unnecessary hospitalizations, forced institutionalization, and expenses to transport the person out of the local area for treatment. To complement the clinical projects, the residency training program has just introduced an Intellectual Disability Specialty educational track offered during years R2 through R4. The panel will take us through the logistics of developing and funding the program, initial challenges on the road to implementation, available resources, clinical services and training components. An interactive format and group discussion will help determine if Intellectual Disability Psychiatry training and utilization of Telepsychiatry could be effective educational and clinical tools for the provision of quality mental

health care for patients with ID and the training of psychiatry residents.

No. 6

Sugar and "Spice" and Nothing Nice: Comparing the Evaluation and Treatment of K2-Induced Psychosis Versus Marijuana-Induced Psychosis

Poster Presenter: Lauren Pengrin, D.O.

SUMMARY:

Synthetic cannabinoids refer to a group of psychoactive chemicals that are infused into dried plant material or as a liquid designed to be used in vaporizers or e-cigarettes. These chemicals are called cannabinoids because they are related to active compounds found in the marijuana plant. However, they may affect the brain much more powerfully than marijuana; their actual effects can be unpredictable and, in some cases, severe or even life-threatening. Many clinicians are now assessing and treating patients who become intoxicated with synthetic cannabinoids, often called "K2 or Spice". In some areas of the country, physicians may not be very familiar with the effects of K2. The presentations differ significantly from the psychosis associated with marijuana and are often much more difficult to treat. K2 induced psychosis tends to be much more severe and difficult to treat than marijuana induced psychosis. Patients often require treatment with antipsychotic medications and inpatient psychiatric treatment. Marijuana induced psychosis is usually self-limiting and does not cause a lengthy duration of distress or inpatient hospitalization. I will be presenting various case studies in addition to a literature review comparing and contrasting the evaluation and treatment of psychosis induced by K2 versus marijuana. The implications of this study will help guide clinicians in their initial evaluation, treatment selections, and follow up care in such cases.

No. 7

Diagnosing and Treating Synthetic Cannabinoid Intoxication in a Patient With New-Onset Psychosis

Poster Presenter: Lauren Pengrin, D.O.

SUMMARY:

A patient with a history of Major Depressive Disorder presented to an emergency department with symptoms of acute psychosis, hypersexual behavior, and autonomic instability. He was unable to give any coherent information upon admission and was extremely agitated and physically threatening toward staff. He attempted to elope from the emergency department and required mechanical restraints. He was given sedatives and admitted to the internal medicine floor for further workup. Internal medicine service considered the differential diagnoses of metabolic encephalopathy, substance intoxication, bipolar disorder, and schizophrenia. The patient was given supportive therapy to address his hypertension, tremor, and agitation. CT imaging of the brain and lumbar puncture were unremarkable. Labs revealed elevated CPK, elevated WBC, and evidence of dehydration. Urine toxicology screening was negative. The patient remained quite disorganized, agitated, and sexually inappropriate the following day. Psychiatry was consulted to evaluate the patient and recommend further treatment. Upon evaluation, he was disoriented, verbally aggressive, and appeared to be responding to internal stimuli. He was unable to provide and history and no next of kin was found to gather collateral information. Given the onset of psychotic symptoms, the Psychiatry team ordered specific toxicology labs to test for recent synthetic cannabinoid use, however the results often take many days to return. The patient was managed with moderate doses of typical antipsychotics and benzodiazepines to address his symptoms of psychosis, hyper-sexuality, and agitation. After 4 days, the patient became more coherent and was able to provide a limited history. He admitted to using what he thought to be marijuana, though he stated he had purchased the drug from a different dealer. The patient said that the "marijuana" looked and smelled different when he smoked it. He reported having no memory of the previous 5 days, including his presentation in the ED or subsequent transfer to inpatient psychiatry, and was ashamed of the actions he had committed during that time. He made a full recovery and was discharged to the community. Synthetic cannabinoids are a major problem in Washington DC and are not included in routine toxicology screens. This case illustrates the difficulty faced by clinicians in identifying acute intoxication with synthetic cannabinoids as the symptoms often mimic other

psychiatric conditions. Standard toxicology screening does not test for synthetic cannabinoids and specific toxicology test results can take days or weeks to return. In this poster presentation, I discuss the importance of correct diagnosis and treatment of synthetic cannabinoid intoxication and the challenges clinicians face in doing so.

No. 8

Symptoms of Psychosis Distract From the Chief Complaint in a Young Patient With Severe, Chronic Schizoaffective Disorder and Stroke

Poster Presenter: Erin Dooley
Co-Authors: Eliza Buelt, Gabriela Pachano

SUMMARY:
The patient is a 33 year old black female with a history of schizoaffective disorder, bipolar type, type 2 diabetes, hypertension, and chronic kidney disease who presented to the Emergency Department complaining of right-sided weakness. In addition, the patient was demonstrating symptoms of mania including tangential thought process, bizarre thought content, and disorganized behaviors including singing and attempting to disrobe. She was noted to have an abnormal gait but otherwise normal neurological exam. She was evaluated by the emergency department, the psychiatry consult team, the community services board, and was "medically cleared" for transfer to another institution for acute mania with psychosis. She was treated and discharged home after about two weeks. Reportedly during this admission she "refused" MRI. The patient returned to the Emergency Department immediately following hospital discharge, requesting medications and a wheelchair for her right sided weakness, which was noted on exam. She was given instructions on how to get medications, and a wheelchair was ordered for delivery to her home the next day. She was discharged from the ER without specialty consultation. Later in the same day, she returned to the ER again with continued complaints of right sided weakness and request for prescribed medications. In the emergency department she became agitated regarding her care and required emergency psychopharmacologic restraint. She was noted to have right hemiparesis, but was again "medically cleared" by the emergency team without evaluation for neurological symptoms. She was seen by the psychiatry consult service and the community services board, and was transferred to a different institution for inability to care for herself. During that admission she was evaluated for stroke and found to have chronic basal ganglia infarcts and possible subacute left thalamic stroke. This patient's stroke symptoms were missed on multiple occasions by multiple evaluators. In addition to the stigma associated with a diagnosis of mental illness, active psychiatric symptoms have the potential to serve as a distraction and may activate unconscious biases, changing the response of caregivers. This case serves as a reminder of the importance of carefully attending to patients' subjective complaints as well as any and all notable objective findings on physical examination. This poster reviews the impact of the stigma of mental illness on access to optimal psychiatric and medical diagnosis and treatment.

No. 9

Everyone Has Trauma Until Proven Otherwise: Our approach in the ER

Poster Presenter: Lidia Klepacz, M.D.
Co-Authors: Sahil Munjal, M.D., Cecilia Asante, Felicia Parris, Alex Pelliccione

SUMMARY:
Trauma is the number one cause of death for Americans between the ages of 1 and 46 years. In the US, rate exceeds 12 other developed countries and does case a reduction of lifespan in the U.S. Each year, trauma accounts for 41 million ER visits and 2 million hospital admissions. We will discuss the physician's role in treating trauma including SAMHSA's 4 R's- Realize impact of trauma, Recognize signs and symptoms of trauma , Responds to patient using trauma informed approach and Resist re-traumatization. Our approach- 1. We do an immediate triage prevent re-traumatization and create a trusted environment. Re-traumatization occurs when the patient feels as if he or she is undergoing another trauma. 2. We inform the patient what to expect in the screening process. 3. Adjustment of tone and volume of speech to suit the patient's level of engagement and degree of comfort in the interview. 4. Approach the patient in a supportive manner. 5. Elicit only the information relevant for determining a history of trauma and possible existence of trauma. Give the patient as

much personal control as possible during the assessment. 6. Avoid being judgmental. We will discuss the principles of patient centered care which have led our rates of restraints being 0.1% in the ER. We will also discuss the six core principles of Trauma-Informed Approach including Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment, Voice and Choice & Cultural, Historical and Gender issues

No. 10

Psychiatric ER as a "Heart and Soul" of Psychiatry: How to Reduce Restraints/Seclusions in the ER

Poster Presenter: Lidia Klepacz, M.D.
Co-Author: Sahil Munjal, M.D.

SUMMARY:

The psychiatric emergency room is the major point of entry to acute psychiatric services for persons with severe mental illness, particularly those who are violent. The rates of restraint/seclusion in the psychiatric emergency rooms range from 8 to 24%. In our opinion, patient centered care and other specific strategies can significantly reduce the incidence of restraints which is corroborated by our incidence of restraints as 0.1% of the total visits to the psychiatric emergency room. Our approach includes the following- 1. Early triage 2. Patient centered care 3. Assess for medical and psychiatric emergencies. 4. Evaluate patients in crisis 5. Evaluate, treat and reassess patients 6. Identify stressors, challenges, 7. Identify the strengths 8. Coordinate care and services in the community for patients with mental illness 9. Assessing the risk of violence against self or others. We, through this poster will explain the various strategies that we use to make out ER safer for our patient and our staff.

No. 11

Share and Share Alike: Integrating Shared Decision Making Into Community Mental Health

Poster Presenter: Shreedhar Paudel, M.D., M.P.H.
Co-Authors: Jesse Robillard, M.D., Oliver Freudenreich, M.D., Rabin Dahal, M.D., Melinda Randall, M.D.

SUMMARY:

Introduction: Shared Decision Making (SDM) emphasizes an interactive process where both clients and practitioners recognize one another as experts and collaborate in setting treatment goals, discussing treatment options, and deciding together on a treatment plan. Although SDM is considered an essential component of recovery oriented psychiatric practice most mental health centers report challenges to implementing SDM in their regular services. Objectives: To design and implement a SDM program in a community mental health center, and to measure SDM utilization, quality of life, medication adherence and decision conflict among clients with severe mental illness (SMI). Methods: Psychiatric rehabilitation staffs (n=15) including nurses, recovery facilitators, and peer support workers participate in ongoing training and supervision in SDM. Training covers the importance of relationships, empowerment, skills training, education, and decision aides. Psychiatric rehabilitation staffs utilize SDM concepts and knowledge while serving people with SMI, and help them prepare for the briefer visit with their psychiatrists. People with SMI are encouraged to share their preferences and opinions about their treatment, articulate requests, and engage in a conversation with the psychiatrist in order to come to a decision. Psychiatrists also regularly use SDM concepts during the brief visits. This is a longitudinal natural outcome study where clients with severe mental illness receiving community based flexible support services with capacity to make medical decision are eligible to participate. The research protocol was approved by institutional review board at Berkshire Medical Center. We collect monthly data on the utilization of SDM as subjectively reported by psychiatrists and rehabilitation staffs. Data on quality of life, medication adherence, and decision conflict are collected using validated questionnaires every 6 months. Results: Out of 44 people with SMI enrolled in the longitudinal study, 2 died of natural causes and 42 were included in the analysis. Thirty four (81%) clients had average of at least 1 SDM visit per month and 13 (31%) had average of 1 SDM visit per week with psychiatric rehabilitation staffs. Similarly, 26 (62%) of them had average of at least 1 SDM visit every 2 months and 13 (31%) had average of at least 1 SDM visit per month with psychiatrists. Conclusion: SDM can be implemented for people with SMI in a community mental health center. Psychiatric rehabilitation staffs

can fulfill a critical role in supporting decision making around treatment, but this needs to be further defined. Analysis of correlation between SDM utilization and quality of life, medication adherence, and decisional conflict needs to be completed.

No. 12

Engagement of Ultra-High Utilizer in the Psychiatric Emergency Service

Poster Presenter: Sina Shah-Hosseini, M.D., M.S.E.
Co-Author: Raj Addepalli

SUMMARY:

Lincoln Hospital is part of the Health and Hospital Corporation which serves the poorest congressional district in the United States and is among the busiest emergency rooms in the country averaging approximately 170,000 visits per year. We present the case of a 42 year old man, with over 600 emergency department visits complaining of various psychiatric symptoms, including symptoms suggestive of substance induced psychosis, substance induced depression, self-reported symptoms of depression which clear up in less than 12 hours, and self-injurious behaviors such as cutting, overdose of medications and conditional suicidal ideation. Despite intensive efforts to engage the patient in outpatient mental health services, substance use rehabilitation, and housing services, the patient has consistently refused or failed to follow-up with referrals. The patient has reported repeatedly that he refuses city shelter services because they are too unsafe, and has engaged in a recurring pattern of using the Emergency Department as a place to sleep overnight, and subsequently requesting discharge in the morning. This patient has been deemed to be an ultra-high utilizer of the Psychiatric Emergency Service, with continuous cycle of requesting care, and then refusing when needs are met. This case demonstrates that current psychiatric and substance use treatments do not meet the needs of this patient, and is part of a significant subset of patients who demonstrate similar behavior. Previous retrospective studies have shown that high utilizers tend to be homeless, have a developmental delay, have personality disorders, history of inpatient psychiatric admissions, uncooperative with treatment recommendations, history of substance use, history of incarceration, and/or poor primary social support. This subset of patients tend to utilize a significant amount of limited clinical resources and may play part in increasing waiting times in the ED. Cases such as these, with patient refractory to engagement, have intensified the debate of developing targeting programming toward this population subset. Hospitals with such a population may benefit from partially reducing the cost of services. Small steps in identification of these subsets of ultra-high utilizers and engagement of these patients can result in significant cost savings. Previous studies have documented efforts in reducing the cost associated with the ED visits of these ultra-high utilizers. However, creative strategies such as designating a small part of the Emergency Department as a safe haven for these patients and as non-treatment areas with some clinical oversight as needed may help in reducing the cost. It would also make available resources for patients who need more acute attention.

No. 13

Adverse Childhood Experience as Predictors of Nicotine, Alcohol, and Drug Use among Patients with Serious Mental Illnesses

Poster Presenter: Simone Anderson, M.Ed., B.S.
Lead Author: Luca Pauselli
Co-Authors: Samantha Ellis, Michael T. Compton, M.D., M.P.H.

SUMMARY:

Background: The association between adverse childhood experiences (ACEs) and the use of nicotine, alcohol, and other drugs has been widely studied and proven in the general population. Cigarette smoking, along with other forms of substance dependence, represent a common co-occurrence among those with serious mental illnesses (SMI). Few studies have focused on the association between ACEs and cigarette smoking, alcohol use, and drug abuse in individuals with SMI. Methods: 143 inpatients with serious mental illnesses were recruited to take part in a larger study. From an in-depth, approximately 4-hour assessment, we gathered information on sociodemographic variables, diagnosis, the Patient Health Questionnaire-9 (PHQ-9), the Adverse Childhood Experiences scale (ACE), the FagerstrÃ¶m

Test for Nicotine Dependence (FTND), the Michigan Alcohol Screening Test (MAST), and the Drug Abuse Screening Test (DAST) to investigate the relationship between ACEs and nicotine, alcohol, and drug abuse. Results: The sample mean age was 33.9±12.0 years, 61.5% were males, 53.1% were African American, and 74.1% had a psychotic disorder. We found modest positive correlations between ACE total score and FTND (?=0.22), MAST (?=0.23), and DAST (?=0.25) in the overall sample. We re-ran the Spearman's correlations by gender, and found that females showed a stronger correlation between ACE and FTDN than males (0.30 vs 0.16), while males had stronger associations between ACE and MAST (0.27 vs 0.16), and DAST (0.33 vs 0.11) compared to females. We then dichotomized FTND, MAST and DAST scores and ran Student's t-tests on the mean ACE score in males and females based on substance use status. Women who smoke had a statistically significant higher ACE score compared to those who did not (5.7±2.7 vs 4.1±2.5), while for men, statistically significant higher mean ACE scores were observed for alcohol users (5.8±2.6 vs 4.3±2.9) and drug users (5.8±2.7 vs 3.9±2.7). Conclusion: The mental health system has been grappling with effective approaches to cigarette smoking, alcohol use, and drug abuse among individuals with SMI. These behaviors, along with many other factors, drive a reduction in life expectancy of over 20 years for this population. Our study suggests that ACEs may contribute to these lifespan-shortening problems; furthermore, differential patterns of association between ACEs and adverse health behaviors exist in men and women. Further research would be useful in this direction since, if confirmed, these findings should drive not only preventive policies for childhood exposure to adverse events but also strategies on trauma-informed care so that early traumatic events will have lesser lifelong impact on patients with SMI.

No. 14
WITHDRAWN

No. 15
The Lingering Trauma and the Impressive Resilience in the War-Torn Great Lakes Region of Africa
Poster Presenter: Kaitlin M. Slaven, M.D.
Co-Author: SuZan J. Song, M.D., Ph.D., M.P.H.

SUMMARY:
The Great Lakes Region of Africa, specifically Rwanda, The Democratic Republic of Congo, and Burundi have endured years of conflict, which heightened with the genocide taking place in 1994 between the Hutus and Tutsis. During that time, estimates of up to 1 million Rwandese were killed and many were displaced. Studies at the time estimated that 94% of people in Rwanda experienced at least one genocide event (witnessing murder of family members, having property or homes destroyed, and having lives threatened). Children became soldiers and women were raped. HIV became a weapon of war across the region. Studies began to emerge soon after demonstrating high prevalence rates of PTSD, depression, and prolonged grief. The fighting continues in many parts of the region to this day, which continues to amplify pathological trauma symptoms. A review of the literature examines what we know about the post traumatic symptoms that remain amongst this population and also highlights the resilience that victims and perpetrators alike have demonstrated. In multiple studies examining this population, rates of PTSD were found in up to 75% and rates up depression up to 77% of people. Based on these results, nearly a quarter of a century later, evidence exists that post traumatic symptoms remain higher in the Great Lakes Region than in many other parts of the world. There is much to learn about trauma and resilience from this area of the world which has endured such a horrific past.

No. 16
Posttraumatic Stress Disorder in Pediatric Populations
Poster Presenter: Nusrat Jahan, M.D., M.B.B.S., M.P.H.
Co-Authors: Muhammad Annas Tahir, M.D., M.B.B.S., Mehtab Rana, M.D., M.B.B.S., Humaira Masoud, M.D., M.B.B.S.

SUMMARY:
Objective: Posttraumatic stress disorder (PTSD) due to its nonspecific presentation in children becomes difficult to diagnose. The main objective of this case report is to diagnose and manage the PTSD symptoms in the pediatric population. Case: 6 Years

Old child with past h/o Pfeiffer Syndrome, attention deficit hyperactivity disorder (ADHD), and obsessive-compulsive disorder (OCD) was brought to the crisis center with reports of worsening aggression and behavioral outbursts that had caused the patient to be picking at his sutures leading to dehiscence of the suture sites. The Patient had sleep problems, increased arousal, hypervigilance, and behavioral reenactment. The Patient's mother reported the patient loses control quite often and there had been multiple episodes of such behavior since the age of 3 years. The Patient had 3 surgeries in the past (at the ages of 2, 3, and 6 years) for the cranial stenosis syndrome. The Patient was diagnosed with ADHD and OCD due to his behavioral symptoms and he has started on the stimulants and selective serotonin reuptake inhibitor (SSRI) 6 months ago. There was no significant improvement in his symptoms. The child was aggressive and did not engage well with the mental status and physical examination. Discussion: The symptoms of PTSD can be subtle and may resemble those of other psychiatric and behavioral disorders. Children who have experienced trauma may exhibit sleep difficulties (frequent awakenings and nightmares), flashbacks, irritability or angry outbursts, trouble concentrating, the behavioral reenactment of the trauma, anxiety, phobias, and social avoidance. PTSD requires that symptoms persist for more than 1month. The undiagnosed cases of PTSD in children predispose them to other psychiatric complications e.g. major depressive disorder, aggression, substance use, suicidal thoughts and suicidal attempts. There are no specific laboratory tests for PTSD. Several psychometric measures, e.g. semistructured interviews or self-report measures are used to evaluate PTSD in children. Child PTSD Symptom Scale (CPSS) is an effective scale with the sensitivity of 84% and specificity of 72%1. Trauma-focused cognitive-behavioral therapy (TF-CBT) is the first-line treatment for PTSD. SSRIs are not FDA-approved for the treatment of PTSD in children. Sometimes symptoms of ADHD may mimic the PTSD. Stimulants have excellent results for ADHD adolescents and good results for children. If stimulant is not improving the symptoms of ADHD, then the health care professionals should re-evaluate the patient for another diagnosis. Conclusion: Pediatric's PTSD may mimic any psychiatric illness, and low threshold needs to diagnose it. Repeated surgical procedures for any congenital anomaly or syndrome can be a risk factor for pediatric PTSD. It is very important for healthcare professionals to be aware of the comorbidities and nonspecific presentation of PSTD before starting management.

No. 17

Social Isolation Leads to Suicidal Ideation Through a Path of Impaired Sense of Self

Poster Presenter: Firouz Ardalan, B.A.

SUMMARY:

Background: There is general consensus amongst current and previous research that both shame and social isolation play a role in suicidality. However, research suggests that shame's role in suicidal behavior may vary across different populations. Nonetheless, there is a need for more research on how shame or sense of defectiveness is related to suicidal risk. This present study tests a path model that social isolation leads to a sense of defectiveness and shame, which in turn leads to increased suicidal risk. Method: Seventy-seven (77) patients were selected from a larger study on the inter-relationships of various aspects of psychopathology. All subjects were recruited from an inpatient psychiatric unit in a large urban hospital. Data was collected and analyzed from two self-report measures and one clinical interview. The scales used were the Young Schema Questionnaire (YSQ-S3), the Interpersonal Support Evaluation List (ISEL-SF) Appraisal, Belonging and Tangible subscales, and the Columbia Suicide Severity Rating Scale (CSSRS). Path analysis was conducted with CSSRS lifetime suicide ideation as the dependent variable, YSQ-S3 defectiveness/shame as the mediating variable, and the three ISEL-SF subscales and YSQ-S3 social isolation as the independent variables. Results: Our results support a model with a path from both ISEL Appraisal (Beta = -.224, p=.028) and YSQ-S3 Social Isolation (Beta = .640, p<.001) to YSQ-S3 Defectiveness/Unloveability. In turn, we found a path from YSQ-S3 Defectiveness/Unloveability to CSSRS Suicidal Ideation (Beta= .515, p=.004). There was no direct effect of YSQ Social Isolation or ISEL Appraisal on CSSRS Suicidal Ideation. There were no significant paths from the ISEL Belonging or Tangible subscales. Discussion: Our results support prior

research showing a relationship between lack of social support, impaired sense of self and suicidal risk. Specifically, it appears that reduced social support has a direct effect on sense of self, which in turn directly impacts suicidal ideation. Indeed our data suggests that the effect of social support on suicidal ideation is fully mediated by sense of self as defective. This highlights the importance of enhancing social support as prevention against suicidal risk.

No. 18

Peer Support in an Outpatient Program for Veterans With Posttraumatic Stress Disorder: Translating Participant Experiences Into a Recovery Model

Poster Presenter: Anusha Kumar, B.S.
Co-Authors: Kathryn Azevedo, Ph.D., Jeremy Ramirez, M.P.H., Elon Hailu, B.A., Adam Factor, B.A., Steven Lindley, M.D., Ph.D., Shaili Jain, M.D.

SUMMARY:
Veterans returning from recent conflicts in Afghanistan and Iraq present with increased rates of post-traumatic stress disorder (PTSD), while veterans from prior service eras continue to seek trauma-based services. Peer support for veterans with PTSD has the potential to resolve ongoing challenges in veteran access and engagement in mental health care. Assessing the value of peer support services requires a thorough understanding of the expected role and the empirical mechanisms of peer support participation in PTSD recovery. To address the current dearth of in-depth qualitative data on these topics, this study interviewed participants from an established outpatient PTSD program, the Peer Support Program (PSP), located in the remote satellite clinics of the VA Palo Alto Health Care System in Northern California. After obtaining IRB approval, 29 PSP veteran participants were interviewed. A domain analysis of 300 plus pages of narrative transcripts generated 24 codes through a grounded theory method. Codes were organized into the following thematic categories: the role of the PSP, positive experiences of the PSP, outcomes of the PSP, and limitations. These results were further synthesized into a theoretical model that 1) defines the role of PSP participation in PTSD recovery and 2) identifies mechanisms by which experiences in the PSP lead to recovery outcomes. A chief category, "Functioning and Reprieve," emerged as the foundation of our model, since it clarified what components of recovery participants seek via the PSP. This finding indicates that out-patient peer support focuses on improving participants' functioning in society and fostering participants' ability to manage difficult emotions. Our subcategories—experiences of comfort, camaraderie, and exposure that produce recovery orientation and connectivity outcomes—describe the mechanisms underlying PSP-mediated recovery. Overall, these findings can help optimize outpatient PTSD peer support programs. They suggest reorienting the training of the certified peer specialists to emphasize functioning and reprieve outcomes rather than specific approaches. They can also communicate to traditional mental health providers what elements of PTSD recovery the PSP uniquely contributes to, which would advance integration of the PSP into the existing VA mental health care framework. Finally, they identify functional outcome measures (level of social support, perceptions of empowerment, quality of life markers, employment status, etc.) rather than clinical measures as the most appropriate for upcoming evaluations on the efficacy of PTSD peer support.

No. 19

Intrapersonal Theory of Sudden Suicidal Tendencies

Poster Presenter: Muhammad Annas Tahir, M.D., M.B.B.S.
Co-Authors: Nusrat Jahan, M.D., M.B.B.S., M.P.H., Zara Muzaffar, Tauqeer Tariq

SUMMARY:
Suicidal behavior has been studied in great detail in context of psychiatric disorders and socioeconomic stressors. Can a person with no history of psychiatric disorder and no or very mild psychosocial stressor claim his life; is a question that is still unanswered. Whenever a bio-psychosocially healthy person commits suicide, a lot of conspiracy theories surface, which are sometimes very farfetched. This theory proposes the possible psychological underpinnings of sudden suicidal tendencies in healthy population and with very low magnitude of distress. Human beings can acquire pathologies by either extrinsic

factors (e.g. microorganisms, unhealthy lifestyle, psychological or physical trauma) or intrinsic factors; where our bodies own systems, genes, enzymes are malfunctioning. All present theories of suicide are centralized around these two factors: extrinsic (psychosocial stressors) and intrinsic (genetic inheritance, chemical imbalance of neurotransmitters). Autoimmunity, where body defense system attacks its own body is an important cause of number of physical diseases. Just like physical immune system, our mind has psychological defense system, called the defense mechanisms. Another one is concept of death reversibility (CODR); in which a child till age 6 to 7 years thinks that death is reversible, has no fear of death and he is also having imaginary friends. According to this theory healthy people who commit suicide, they land back to the stage when a child thinks that death is reversible via a defense mechanism called regression. Cause of regression could be sudden low intensity psychosocial stressor. It is a kind of psychological autoimmunity; a stage of mind that served its role in the protection during childhood, gets activated at a very high intensity in adults. A person with this state of mind will no longer fear the death. He may involve himself in dangerous risky behavior. Person may commit suicide and or even homicide. All this is happening at subconscious level. This theory shines light on the psychological processes through which a normal person may commit suicide or homicide. What sets apart this theory from others is it deals with the entirely new concept of psychological autoimmunity.

No. 20

New Approach to Decreased Suicidality Among Arrestees

Poster Presenter: Sureshkumar H. Bhatt, M.D.

SUMMARY:

Mental health problems are more prevalent among inmates than in the general population. However, there is a limited amount of hard data documenting health care in incarcerated populations. Mental illness is particularly difficult to manage in the correction setting as the high-stress environment and the loss of individual freedoms can induce psychiatric problems and destabilize preexisting mental illness; this translates into a dramatically increased risk for suicidal behavior. The high frequency of malingering and antisocial personality can cloud suicidality. Timely assessment of new arrestees, early detection of suicide risk factors, and proper management significantly reduce suicide risk in inmates. This study was performed to delineate the frequency of mental illness and substance abuse among arrestees at the St. Tammany Parish Jail (STPJ) in Covington, Louisiana. This information was utilized to risk stratify arrestees as to their risk for self-harm using a Psychiatric Risk Index (PRI) classification system. The three main aspects of the study were to identify arrestees at risk for life-threatening withdrawal from abused substances, determine how rapidly patients should be seen by a mental health professional, and provide a safe environment for high risk inmates. 7756 inmates were evaluated in 2015 and pre-screened for medical and mental health problems immediately upon arrival. Medical, psychiatric, and substance abuse histories, including details about suicidal behaviors, were done within six hours of arrest. Urine drug test was performed upon consent. All arrestees were classified with a PRI score, ranging from 1 (very low risk) through 5 (crisis-level). Those categorized as PRI 5 were immediately placed on suicide watch. In 2015, the 1150-bed jail booked an average of 643 arrestees per month. 20% of arrestees reported mental illness; 7% reported a prior suicide attempt; and 1% had active suicidal thoughts at intake. 55-65% of arrestees were actively using drugs; 27.9% were under the influence of alcohol, and 65-75% of inmates were using drugs and/or alcohol at arrival. 54% of all health care appointments were related to mental health. 349 out of 624 appointments were with the psychiatrist, with an average wait of 1 day. An average of 50 inmates reported suicidal thoughts or intent each month and were placed on suicide watch. There were 3 unsuccessful suicide attempts in 2015. 3 inmates were restrained from self-harm. There were no mental health-related grievances submitted. The Bureau of Justice Statistics estimated the 2013 national suicide rates in jails to be 46 deaths per 100,000 inmates. At the STPJ, there were 3 successful suicides in the last 12 years, which amount to 24.5 deaths per 100,000 inmates. Our PRI system helps jail health staff rapidly identify arrestees with unstable mental illness, including

those most at risk for suicidal behavior. Using PRI, the jail has reduced inmate suicides to 53% of the national average.

No. 21

How Prescription Monitor Program Can Help Psychiatric Practice

Poster Presenter: Sureshkumar H. Bhatt, M.D.

SUMMARY:

It is more difficult for psychiatrists to treat substance abuse and mental health problems when they occur concurrently. Abuse of prescription medications is a serious and growing epidemic in the United States, and drug overdose has now eclipsed motor vehicle accidents as the leading cause of accidental death in this country. Half of all overdose deaths result from abuse of prescription drugs, with opioid pain killers being the chief offenders. Despite increased awareness of this problem and tighter regulatory control, addicts still find it easy to procure prescription drugs for recreational use. The 2013 National Survey on Drug Use and Health revealed that the majority of illicitly used pain killers were obtained from medical professionals and not drug dealers. Hidden prescription drug abuse may delay the diagnosis of other mental health disorders and can significantly complicate the treatment of those conditions. Prescription drug monitoring programs (PMP) provide a valuable resource to physicians. Such programs can help curb the rampant abuse of prescription drugs, help psychiatrists identify undiagnosed substance abuse disorders, and improve the treatment of other primary psychiatric disorders. This study was conducted in 2016 at the St. Tammany Parish Jail in Covington, Louisiana, in an effort to identify patterns of prescription drug abuse among selected patients in the jail's Psychiatry Clinic. Louisiana PMP database was referenced whenever a patient reported poly psychotropic therapy or when a patient's reported medication regimen seemed unusual for the stated diagnosis. The Louisiana PMP was consulted for 602 patients enrolled in the jail's Psychiatry Clinic. 79.23% of the patients (n=477) were male and 20.76% (n=125) were female. 69% of the patients had been prescribed a controlled drug that was not reported during the initial Psychiatry Clinic encounter. The following trends were observed: 1) The most commonly prescribed controlled drug classes were opioids and benzodiazepines; 2) The most common non-reported medications were dextroamphetamine/amphetamine and buprenorphine/naloxone; 3) The majority of patients had multiple prescribers for the same medications; 4) Many patients had been prescribed both stimulants and sedatives; and 5) Stimulant prescription was quite common among patients diagnosed with bipolar disorder. A prescription monitoring program can be a useful tool, helping psychiatrists to identify unreported use of prescription medications. This can facilitate the recognition of substance abuse disorders and improve the treatment of many mental illnesses that may be exacerbated by prescription drug use. Psychiatrists should make it routine practice to check a state's PMP before they diagnose a patient or formulate a treatment plan.

No. 22

Treatment of Opioid Use Disorder: Addressing a Serious Epidemic

Poster Presenter: Sahil Munjal, M.D.

SUMMARY:

There has been an escalating opioid crisis in the country including the lower Hudson Valley as well. The statistics paint a picture themselves with more than 200 people dead in the Lower Hudson Valley from pain-pill abuse since 2010 and deaths in Westchester County have more than doubled from 21 to 47 per year. A recent letter by the surgeon general has emphasized the need for screening our patients for opioid use disorder and to provide or connect them with evidence-based treatment services. We want to improve the knowledge and understanding of these interventions/services among our clinicians. We designed and e-mailed a brief, voluntary, anonymous questionnaire to clinicians assessing their knowledge regarding the evidence-based treatment of opioid use disorder. We then had a grand round presentation on the various evidence-based medication assisted treatment options available to treat opioid use disorder, which includes methadone, buprenorphine and naltrexone. We then followed it up by training the clinicians on how to assemble and administer naloxone in a patient with opioid overdose. It is

essential for the clinicians to be familiar with these tools so they can better address this escalating crisis.

No. 23

Assessing Barriers of Clinicians Treating Patients With Tobacco Use Disorder

Poster Presenter: Sahil Munjal, M.D.
Co-Author: Rachel Zinns, M.D.

SUMMARY:

Tobacco use is very common among patients with psychiatric disorders and does account for highest-ranking cause of death in this population. Yet, smoking by patients continues to be an afterthought for most psychiatrists and behavioral health professionals. Nicotine dependence (now tobacco use disorder) has been included in the DSM since 1980, yet it may be the only substance use disorder that is not routinely diagnosed and treated in mental health settings. The 2008 update to the US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence recommends that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting. This QI project was undertaken to assess and remove barriers in treating patients with tobacco use disorder in our outpatient setting. We will report on a survey conducted to assess the attitudes, perceived barriers & knowledge base of our clinicians as well as a chart review conducted both to assess the prevalence of tobacco use disorder in our clinics and to establish a baseline of our current practices. We will describe a series of didactic sessions educating the clinicians regarding the FDA recommended treatment strategies and the various toolkits available to treat patients with tobacco use disorder. We will then report on outcomes in screening and treatments offered at specific time points after the educational sessions.

No. 24

Code Grey: What We Learned So Far!

Poster Presenter: Jasra Ali Bhat
Co-Authors: Lidia Klepacz, M.D., Lidia Klepacz, M.D.

SUMMARY:

Mr.X, a 49 year old Caucasian male with past psychiatric history of bipolar-I disorder, alcohol use disorder, multiple rehabs was brought to adult ER by EMS after he cut his left forearm and flexor tendons with a knife .On evaluation patient , reported that he was homeless but living with ex- wife post his recent discharge from a rehab . Yesterday, patient relapsed on alcohol and ex-wife asked got upset and asked him to leave her house. Patient got frustrated and left his ex-wife's house went to the woods and cut his left forearm with a sheath knife. He had also been non-compliant with his medications for approximately 2 years as he felt they weren't helping him. Psychiatry was consulted to evaluate for suicidality. Upon evaluation, patient was found to have no remorse about his actions and lacked insight into his actions. He was guarded and upon further evaluation was considered a threat to self and others and he met the criteria for inpatient psychiatric evaluation. Upon transfer to psychiatric ER, patient was belligerent, agitated and irritated. He was angry and wanted to leave AMA. He was evaluated again by the ER attending and met the criteria of inpatient psychiatric admission as evidenced by his serious self- injurious behavior, impulsivity, mood swings, depression a, low frustration tolerance and violent threatening behavior. Verbal and behavioral intervention was used but patient didn't respond. He was offered oral medications to calm down but he refused. For the sake of safety of patient and others a code grey was called. The code went on for more than 1 hour and about 10 or more staff members were involved. Staff members felt really strong feelings- fear, anxiety etc. post this code grey. This led to the concern of awareness regarding code grey - different types, risks factors involved and ways to premeditate it. Code Grey seems to be psychiatric equivalent of code blue. Code grey is not only as important as code blue but in fact can be more dangerous .A violent patient can not only be a threat to self but to others- staff and patients as well. A lot of money - in terms of manpower, disability from code grey gone wrong and medications gets spent on the code greys. It can also lead to trauma for the staff as well as the patient. A way to reduce it will not only save expenses but also save patient and staff from trauma. If one could anticipate code greys from the first look of the patient, a lot of money, time and bad experience can be diverted. In this presentation, we aim to educate the trainees about the types of code

grey, risk factors involved, treatment dogma, early recognition of code grey and the ways to reduce it.

No. 25
WITHDRAWN

No. 26
Countertransference Process Group in Residency Training: An Interactive and Personalized Approach to Study and Explore Psychodynamic Concepts
Poster Presenter: Kathryn Q. Johnson
Co-Author: Christian D. Neal, M.D., M.P.A.

SUMMARY:
Psychotherapy training is decreasing, specifically psychodynamic, due to greater emphasis on psychopharmacology. Additionally, trainees often find psychodynamic concepts abstract and inaccessible. Psychiatric trainees at Virginia Tech Carilion School of Medicine organized a monthly transference/countertransference process group to explore emotional reactions and examine ambivalence in the therapeutic dyad. All trainee levels are included and an attending physician facilitates and provides clarification of psychodynamic concepts. Transference and countertransference issues in the clinical encounter are discussed, with the aim of encouraging a psychodynamically-informed approach to patient care. Readings are assigned and members are encouraged to bring clinical material to discuss. This informal and personal group approach fosters self-reflection and provides an opportunity for "self-analysis". It also promotes understanding and awareness of complex emotions in the clinical encounter, with delivery of care and in the mind of the psychiatrist. Participating in this group encourages trainees to analyze the influence of their feelings on treatment decisions and promotes attention to physician wellness and improved patient care. In addition, it decreases the abstract nature of psychodynamic psychiatry in clinical practice.

No. 27
Integrating Recovery Oriented Cognitive Therapy for Schizophrenia Into the Medication Management Visit: Ten Pearls for Moving Beyond Symptoms to True Recovery
Poster Presenter: Judith Katz, M.D.
Co-Authors: Aaron Brinen, Psy.D., Ashley Un, M.D., Irene Hurford, M.D., Paul M. Grant, Ph.D.

SUMMARY:
The form of psychiatric care that most individuals with a schizophrenia spectrum diagnosis receive, at minimum, is medication management, which makes these visits a critical part of treatment and a terrific opportunity to promote recovery. Recovery Oriented Cognitive Therapy (CT-R) for schizophrenia is an empirically-supported treatment approach shown to reduce avolition, and positive symptoms. CT-R was developed to engage even the most symptomatic individuals through developing interests and aspirations and actively pursuing the life of their choosing. CT-R involves individualized formulations, based on the cognitive model, that guide interventions to empower individuals to overcome barriers to recovery, including positive, disorganized, and negative symptoms of schizophrenia. Using a CT-R framework to guide medication management requires a shift in focus of the visit to the individual's interests and long-term aspirations. This provides the context for a discussion of medications. Prescribers can then elicit more valuable, reliable, and organized clinical data, produce greater adherence to treatment, experience fewer missed appointments, and increase interest in supporting services (e.g., labs, case management). We present practical steps for integrating the techniques and principles of CT-R within medication management visits. The 10 pearls include tips for activating patients even within a short medication management appointment, structuring the visit to be maximally effective, identifying key beliefs associated with negative symptoms, delusions, hallucinations and thought disorder, designing interventions that weaken negative beliefs and strengthen positive beliefs, and assigning action plans in a manner that does not reinforce negative beliefs.

No. 28
"Home Groups": Combining Peer and Clinical Support at Community Mental Health Centers
Poster Presenter: Thomas Styron, Ph.D.
Co-Author: Sarah Kamens, Ph.D.

SUMMARY:

Community Mental Health Centers (CMHCs) are increasingly recognizing the uniqueness of services that can be provided by peers, or experts with personal experiences of illness and recovery. Peers provide an invaluable resource by sharing their stories of recovery, fostering hopes, facilitating community-based activities, and using personal experience to help clients navigate the mental health system. Despite the growing peer-support movement, many clinicians and administrators remain unfamiliar with the ways in which peer and clinical services can be integrated to improve the quality and efficiency of services. This poster will introduce the concept of 'home groups,' which are hybrid, co-facilitated groups that combine peer and clinical services into one weekly session. Home groups allow members to receive routine clinical care while benefiting from the validation and social support of a peer. In addition, home group members work together to find collaborative solutions to case management needs. The poster will address common scenarios that arise in groups that are co-facilitated by peers and clinicians; it will also address ways in which home groups provide collaborative and cost-effective solutions to institutional challenges by enhancing community cohesion and fostering alliances within CMHCs. The poster presenter will encourage visitors to reflect and ask questions about how they might integrate home groups into their existing practice or organization.

No. 29

Saying Hello to Bias

Poster Presenter: Ayana Jordan
Co-Author: Kali D. Cyrus, M.D., M.P.H.

SUMMARY:

Healthcare disparities arise from a complicated series of events involving individuals, systems, and the environment at times. While disparities in care are influenced greatly by structural inequality, we must also examine the role of the provider in exacerbating the gaps in access, treatment, and outcomes for minority groups. Additionally, the role of the provider presents itself as a notable topic worth addressing through medical education. For example, there is a growing body of literature examining the link between physicians' implicit biases and decision making that disadvantages marginalized populations. Using different learning modalities, our workshop describes how bias influences our cognition, how bias operates within our personal and professional context, and how our biases are informed by the history of discrimination within this country. Participants are asked to take an implicit assumption test of their choice before attending this lecture, to make conscious individual bias and understand how this may impact care. In addition to discussing bias, we outline other key sociological concepts such as prejudice, racism, and privilege. Using historical examples such as the Dred Scott case, we discuss how these sociological factors arise out of the context of legally enforced discrimination in the United States. Through a group discussion, we highlight the remnants of disadvantaging policies that continue to contribute to the institutionally enforced oppression of vulnerable populations. Then audience members will pair off for a "speed dating" exercise to delve into recognizing personal examples of privileges that marginalized populations may not have. After covering this material, we apply concepts to cases involving real-life scenarios reflecting the complexity of interactions with colleagues, patients, and our greater medical community. Lastly, we introduce and encourage participants to outline strategies to addressing the role of provider bias. Given the sensitive nature of this discussion, fewer presenters were chosen who could effectively convey the information and engage the audience.

No. 30

Parachute NYC: What Is the Psychiatrist's Role in a Dialogical, Non-Hierarchical Model?

Poster Presenter: David C. Lindy
Co-Authors: Neil Pessin, James Mills, Adam Kaufman, Terrance Roye

SUMMARY:

Parachute NYC uses an innovative model to treat people experiencing psychotic symptoms which blends the psychopharmacologic medical model with the dialogically oriented Needs Adapted Treatment Model. Parachute's main treatment vehicle is the network meeting in which the "patient" and members of his/her natural social system (family, partners, friends) and two Parachute staff meet in

the home as often as necessary to allow problems and solutions to emerge from the evolving dialogue. Network meetings are non-hierarchical and non-coercive; all treatment decisions are transparent; all voices equal. This is a significant departure from other treatment models for similar populations, e.g., ACT. At the same time, psychiatric diagnosis, risk assessment, and psychopharmacologic treatment are performed and offered as indicated. In parallel to the treatment model, Parachute teams strive to be non-hierarchical and attempt to give equal voice to peer specialists, social workers, family therapists, nurses, and psychiatrists or other prescribers. Operated by the Visiting Nurse Service of New York's Community Mental Health Services since 2012, we have learned that implementing this model can be both challenging and enriching. In this presentation we will present perspectives from a Parachute psychiatrist, peer specialist, and team leader to address such questions as: How does this more collaborative approach among team members influence the care of Parachute patients and families? How do the members of the team experience the shift from top-down, traditional care to a sharing of power across roles? Where does this leave the team psychiatrist? We will also present Parachute outcome data and discuss the ways in which the blended model contributes to these outcomes. We will actively invite audience participation and encourage audience members to bring their own experiences and questions about Parachute NYC.

No. 31
Integration of Healthcare: A Transformative Model
Poster Presenter: David C. Lindy
Co-Authors: Mollie Judd, Manisha Vijayaraghavan

SUMMARY:
As part of Medicaid redesign, New York State is transforming the care provided to high cost users of Medicaid, the highest costs being those attributed to patients with behavioral health diagnoses. One vehicle for this transformation has been the Health Home program which integrates care through the utilization of improved treatment protocols, care coordination, a shared plan of care between all providers and health information technology. NY State has also implemented the 'delivery system reform incentive payments program' (DSRIP) to achieve the triple aim: transform our delivery of care with innovative integrated care models and improve the health of populations while reducing per capita costs. DSRIP's Health Home Care Coordination model focuses on ensuring success through three clinical projects: the Health Home at Risk Care Coordination program to expand access of care coordination services to higher risk patients who appear on a trajectory of decreasing health and who are at risk of re-hospitalization for their SMI diagnosis; Care Transitions Critical Time Intervention (CTI) project, a time-limited, evidence-based practice that seeks to reduce avoidable hospitalizations and ER usage for members with schizophrenia and/or bipolar disorder through the facilitation of community integration and support, and the evidence based practice Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model, fully-integrated care in primary or behavioral health settings to treat mental health conditions such as depression and anxiety, which require systematic follow-up due to their persistence. We will describe the NY State Health Home and the DRSIP program in detail, our outcomes and efficacy of these new innovative DSRIP initiatives.

Friday, October 20, 2017

Poster Session 2

No. 1
When Patients Supplement: A Case of Kava Kava Delirium
Poster Presenter: Shanique Ampiah, M.D.
Co-Authors: Kathleen Crapanzano, Venugopal Vatsavayi

SUMMARY:
Introduction: Complementary and Alternative Medicines (CAMs) are attractive to patients because of inadequate treatment response to traditional medications, accessibility, affordability and the lure of 'natural' remedies. However, the use of CAMs is not without risk. One such supplement is Kava Kava or Piper methysticum, a South Pacific herb traditionally used for its anxiolytic and medicinal properties. We present the following case of a patient admitted for Kava Kava induced delirium.

Case Description: Mr. G is a 63 year old Caucasian male who became delirious after excessive Kava Kava ingestion. Although he was being treated by a psychiatrist for MDD, GAD, OCD, and benzodiazepine use disorder, he had been supplementing his psychotropic medications with Kava Kava 500 mg BID (capsules or ethanol based liquid formulation). The recommended maximum daily dose is 120-250 mg (Teschke et al, 2013). Over the last year, he increased his intake to several bottles daily. EMS was called after patient was found on floor in his own vomitus and with an altered mental status. He was managed on a diazepam taper, with quetiapine, and the resumption of his outpatient medications. At follow up visit, he had stopped taking Kava Kava and was seeking substance abuse treatment. However, within 2 months of discharge, he was taking another CAM supplement in addition to his prescribed medication regimen. Discussion: Despite limited data to support their efficacy, CAM use is on the rise with up to 50% of patients being treated for psychiatric disorders taking supplements (Larzelere et al, 2010). Even more concerning is that 79% of patients do not disclose their supplement use to their physicians because they consider them to be 'natural' or simply are not asked (Freeman et al, 2010). However, with no stringent regulation, all kava supplements are not created equally and varying extraction techniques and levels of kavalactones increase the risk of adverse effects. These include dermopathy (dry, scaling skin), drowsiness, cerebellar dysfunction, movement disorders and vertigo (Sarris et al, 2011), in addition to an association with hepatotoxicity and the potential for pharmacokinetic drug interactions (Showman et al, 2015). With the allure of naturopathic medicine on the rise, it is imperative to explore patients' use of supplemental medications to prevent potential harm.

No. 2

Managing Medical Comorbidities on the Inpatient Psychiatric Unit

Poster Presenter: Jayanta Chowdhury, M.D.
Co-Authors: Luisa Gonzalez, Panagiota Korenis, M.D., Monika Gashi

SUMMARY:
Psychiatric patients have high incidence of medical comorbidities. Several studies have indicated that patients with severe mental illness have a higher prevalence of diabetes, hypertension, smoking related illness and complications due to psychotropic medications side effects. Patient with severe mental illness may have limited social support, barriers in accessing health care, and lack of awareness of the potential medical risk. These untreated medical conditions can worsen when a noncompliant psychiatric patient decompensates which leads to their hospitalization. When a patient arrives on the psychiatric inpatient service, emphasis is primarily focused initially on stabilization of psychiatric symptoms and the medical comorbidities can at times be overlooked. Therefore, integrating both mental and physical health care on the inpatient service can be challenging and can delay adequate and timely medical care. Optimal management demands awareness of these existing and potential medical comorbidities starting on the inpatient unit. Treatment plan strategies and guidelines for managing medical comorbidities on psychiatric inpatient service will be discussed.

No. 3

A Critical Intervention at a Critical Time: Providing Access to Pediatric Mental Health Care Through a Collaborative Care Model

Poster Presenter: Scott B. Falkowitz, D.O.
Co-Authors: Rajvee Vora, Andrew Tucci, Christina D. Gerdes, M.D., M.A., Carla Gabris

SUMMARY:
Background: At this time, one in five children in the United States suffers from some form of mental illness, with only 20% of these children ever receiving treatment. Half of all lifetime mental illnesses begin by age 14, with early intervention providing an opportunity to reduce long-term morbidity. Approximately 75% of children and adolescents with psychiatric disorders are seen in the pediatrician's office, but multiple barriers impede execution of mental health care delivery. There have been increasing efforts to identify methods of integrating behavioral health care into the primary care environment. At present, the collaborative care model has the most robust research evidence base for improving quality of care, health outcomes, lowering costs, and increasing satisfaction for both patients and Pediatricians. This

project utilized the collaborative care model in a primary care Pediatric clinic to demonstrate effective treatment of mild to moderate depression and anxiety. This represents a novel implementation of this care delivery model, as the majority of research to this point has been in adult primary care. Methods: Following the collaborative care model, a behavioral health care manager (BHCM) was integrated into a primary care clinic five days a week. The BHCM assists the primary care provider (PCP) with the identification and treatment of patients with behavioral health conditions. The BHCM provides a range of services including: patient education, short term evidence-based psychotherapy, monitoring of treatment response, and facilitating psychiatric consultation between the PCP and their supervising psychiatrist. The BHCM tracks each patient in a HIPAA protected registry and presents each patient to the consulting psychiatrist. The BHCM's patient registry was used to monitor clinical outcomes including the number of patients seen, office visits, ED diversions, outside behavioral health referrals, initiation of psychotropic medications and average change in PHQ9 scores. All the outcome measures reflect collaborative care provided from September 2016 to November 2016. Results: The BHCM saw a total of 126 patients with a total of 246 office visits. There were 14 ED diversions. The BHCM assisted with 31 outside behavioral health referrals. A total of 20 patients were started on a psychotropic medication by the PCP with consultation from the psychiatrist. The average PHQ9 decreased by 9 percent during this period. Conclusion: Implementation of the collaborative care model in this setting was successful at enhancing access to effective evidence-based behavioral health treatment, decreasing the number of avoidable ED visits, and helping to deliver efficient mental health care to a population in dire need of it.

No. 4
WITHDRAWN

No. 5
The Impact of Health Homes on Primary Care Service Use Among Medicaid Beneficiaries With Serious Mental Illness
Poster Presenter: Michael Flores, Ph.D., M.P.H.
Co-Authors: Omar Galarraga, Ph.D., Ira Wilson, M.D., M.Sc., Benjamin L. Cook, Ph.D., M.P.H., Amal Trivedi, M.D., M.P.H.

SUMMARY:
Objective.The purpose of this study is to determine the extent to which one state's Health Home initiative impacted access to and utilization of primary care services for Medicaid beneficiaries with Serious Mental Illness (SMI). Methods. Using Rhode Island Medicaid claims (2009-2013), we employed a quasi-experimental difference-in-differences approach with propensity score weighting to evaluate changes in service use before and after the introduction of Health Homes. The predictive margins method was used to predict access and utilization for treatment and control groups in the pre- and post-intervention periods. The treatment group (N=6,252) were Medicaid beneficiaries ages 18 to 64 with a diagnosis of SMI (major depressive disorder, bipolar disorder, or schizophrenia) that participated in Health Homes. The comparison group (N=4,128) possessed similar characteristics as the treatment group but did not participate in Health Homes. Primary outcomes to assess Health Home's impact were access to primary care (dichotomous) and number of primary care visits (count), overall and for commonly experienced physical health conditions (chronic obstructive pulmonary disease (COPD), cardiovascular disease, diabetes, hypertension, and obesity). Results. At baseline, Health Home and comparison groups were similar on pre-intervention factors. Among Health Home participants, the proportion having at least one primary care visit increased from 83.3% in the pre-intervention period to 92.0% in the post-intervention period. The concurrent trend for the comparison group was 85.6% to 87.0%, yielding an adjusted difference-in-difference of 7.3% (95% CI= 4.6 to 10.0). Similarly, a higher proportion of Health Home participants, relative to the comparison group, experienced at least one primary care visit for COPD, diabetes, hypertension, and obesity (all $p<0.05$). No significant differences existed between Health Home and comparison groups in having at least one primary care visit for cardiovascular disease. Among Health Home participants, the number of primary care visits increased from 722.0/100 person-years in the pre-intervention period to 1,778.6/100 person-

years in the post-intervention period. The concurrent trend for the comparison group was 795.2/100 person-years to 1,003.1/100 person-years, yielding an adjusted difference-in-difference of 848.7/100 person-years (95% CI: 783.0 to 914.6). Estimates also suggested Health Home participants had an increase in the number of primary care visits for COPD, diabetes, and hypertension (all $p<0.05$), relative to the comparison group. No significant differences existed between Health Home and comparison groups in the number of primary care visits for cardiovascular disease and obesity. Conclusions. Investment in the integration of primary care into community mental health settings can improve access to and utilization of primary care services for individuals with SMI.

No. 6

Missing From the *DSM-5*: Lack of Physical Exercise

Poster Presenter: Lauren Pengrin, D.O.

SUMMARY:

It would be difficult to identify a more important etiological agent in medicine, including psychiatry, than "lack of physical exercise." Lack of physical exercise has a major role in serious illnesses such as cardiovascular diseases, osteoporosis, and cancer. Lack of physical exercise has a much broader impact than many of the other behaviors listed in the DSM-5. For example; manic behavior, presence of delusions, catatonia, substance use, compulsions, depersonalization, narcolepsy, are all found in DSM-5; but not the behavior of a lack of physical exercise. More than 40% of DSM-5 conditions have an etiological agent with a behavioral component, but none compare in magnitude to a lack of physical exercise. This "lack of physical exercise" is ignored by psychiatry even though recognized by the rest of medicine. In ICD-9-CM, its code was V69.0. In ICD-10-CM, it is Z72.3. However, there are no codes in DSM-5 allowing psychiatrists to include lack of physical exercise when assigning a diagnosis. Currently, more research is being done to further explore this link between physical exercise and psychiatric symptoms. Now more than ever clinicians are advocating for increased education for patients regarding the use of exercise as a treatment modality for psychiatric symptoms. We will review the literature on exercise levels and mental health and investigate this connection further. In this poster presentation, we aim to present a case for the importance of including a qualifier for "lack of physical exercise" in the DSM-5 and explore the impact this would likely have on the evaluation and treatment of psychiatric illness. A review of the literature on exercise levels and mental health establishes the case for including ICD-10-CM's "Lack of Physical Exercise, Z72.3" in future DSM editions.

No. 7

Enhancing Access to Effective Psychiatric Care Through the Collaborative Care Model

Poster Presenter: Christina D. Gerdes, M.D., M.A.
Co-Authors: Rajvee Vora, Scott B. Falkowitz, D.O., Andrew Tucci

SUMMARY:

In 2015, SAMHSA's National Survey on Drug Use and Health estimated that 16.1 million adults in the U.S. had at least one major depressive episode in the past year.1 For multiple different reasons, including lack of access to psychiatric care, primary care settings have become the largest provider of mental health services in the U.S. Approximately 60 percent of patients being treated for depression in the U.S. receive treatment in primary care settings.2 To address these needs, many primary care providers are integrating behavioral health care services into their practices. Currently, the collaborative care model has the most robust research evidence for improving mental health care provided in the primary care setting and can significantly improve quality of care, health outcomes, lower costs, and increase satisfaction for both patients and primary care providers. This project demonstration uses the collaborative care model in a primary care clinic to effectively treat mild to moderate depression and anxiety. Methods: Following the collaborative care model, a behavioral health care manager (BHCM) was integrated into a primary care clinic five days a week. The BHCM assists the primary care provider (PCP) with the identification and treatment of patients with behavioral health conditions. The BHCM provides a range of services including: patient education, short term evidence-based psychotherapy, monitoring of treatment response, and facilitating psychiatric consultation between the PCP and their supervising psychiatrist. The BHCM

tracks each patient in a HIPAA protected registry and presents each patient to the consulting psychiatrist. The BHCM's patient registry was used to monitor clinical outcomes including the number of patients seen, office visits, ED diversions, outside behavioral health referrals, initiation of psychotropic medications and average change in PHQ9 scores. All the outcome measures reflect collaborative care provided from September 2016 to December 2016. Results: The BHCM saw a total of 132 patients with a total of 313 office visits. There were 24 ED diversions. The BHCM assisted with 89 outside behavioral health referrals. A total of 45 patients were started on a psychotropic medication by the PCP with consultation from the psychiatrist. The average PHQ9 decreased by 9 percent during this period. Conclusion: The implementation of the collaborative care model in this primary care clinic was successful at enhancing the population's access to effective evidence-based behavioral health treatment and decreasing the number of avoidable ED visits. In addition, a significant amount of these patients were started on a psychotropic medication within the primary care setting under the guidance of a consulting psychiatrist.

No. 8

Using a Wiki to Improve Residents' Competency in Community-Based Care and Resource Management

Poster Presenter: Christina D. Gerdes, M.D., M.A.
Co-Authors: Patrice Malone, Eileen Kavanagh, M.D., Melissa Arbuckle

SUMMARY:

Background Resource management is an invaluable skill that encompasses the ability to coordinate access to community resources, consider relative cost of care, and balance the interests of the patient with resources. Community-based care includes recognizing the importance of community mental health resources and being able to coordinate care with community programs. Psychiatrists use both of these skills in their daily practice and it is imperative that resident trainees acquire these skills. We undertook a quality improvement project which incorporated the use of a wiki page (an editable website which allows users to collectively manage and share information) to help residents effectively refer patients to various resources available in the community. Methods We surveyed residents treating patients in the Residency Clinic and Comprehensive Psychiatric Emergency Program (n=21) about their knowledge and comfort in providing community based resource services using a 4-point Likert scale. A wiki page was created, which consisted of information for various resources such as low cost psychotherapy clinics, substance rehabs, mobile crisis referrals, sliding scale medical clinics, shelters, and food pantries that residents could access quickly and easily to identify useful supports for their patients. The wiki was organized in a way that users could identify agencies by location (i.e. borough), as well as, by categories. There was also helpful information to assist with identifying appropriate resources like directions for patient referral, insurance requirements, fees charged, and if the agency was currently accepting patients. The residents were polled at 6 months after being given access to the resource page regarding their attitudes and comfort towards providing community based resources to their patients. Results In the initial survey, 20% of residents indicated that they felt comfortable with coordinating access to community resources for their patients. Approximately 27% of the resident felt that they could balance the needs of their patients with the available community resources. Around 26% felt that they knew how to talk to their patients' about referrals. In the survey completed after having access to the resource page for 6 months, 48% of residents felt comfortable with coordinating access to community resources for their patients. Approximately 72% of the resident felt that they could balance the needs of their patients with the available resources and 95% felt that they knew how to talk to their patients' about referrals. In addition, 86% of residents said the website was user friendly and 90% of residents indicated that they would recommend the website to their colleagues. Conclusions Using current technology, we created an easily accessible and up-to-date information page for residents to refer to when providing medical, psychological, and social resources in the community for their patients which facilitated access to care.

No. 9

Telepsychiatry-Assisted Follow-Up Engagement of Treatment Dropout Substance Users

Poster Presenter: Raju Bhattarai

SUMMARY:
BACKGROUND Opioid Substitution Treatment (OST) is a harm reduction approach for Intravenous drug users to shift them to oral Buprenorphine or Methadone. After a period, many of these clients drop out facing an increased likelihood of relapse. In such individuals a comprehensive approach right from the beginning of substance use treatment is essential. In India, OST is run by National AIDS Control Organization (NACO) and due to nationwide shortage of mental health professionals, integrated treatment approach is unaccomplished in majority of centers. Existing literature supports the role of economic methods such as tele psychiatry to facilitate mental health professionals' reaching out to substance using clients. Brief intervention is useful in substance use population during different phases of drug treatment. Given the low psychiatrist/population ratio in India, tele psychiatry assisted brief intervention could be a viable alternative for drop out population. By linking the psychiatrists to substance users in remote locations, tele-psychiatry could enhance treatment adherence and promote follow up. METHODOLOGY NACO counsellor at every OST center regularly visits the non adherent clients' homes to report the reasons of treatment drop out. Sixty client clients from the OST program at Gorakhpur, North India, who had treatment drop out history of preceding 3 months were contacted through phone. Every week 10 clients were contacted and home visits were made to 4 willing clients in each week. Altogether, 32 clients consented for meeting over a period of 2 months. Meeting was conducted at home in presence of at least one family member as well as on a one to one basis. A 20 minutes session was conducted by the counsellor. It began with detailing the family about the purpose of the visit followed by obtaining an informed consent. Demographic details were noted and instructions were given for self administration of 'Reason for Leaving Treatment Questionnaire' (RLTQ)'. After this, the facilitator connected the client to the psychiatrist through the medium of a tablet device for one to one brief intervention session. This was followed by closure which included a group session with client and the family members to address their queries. Clients were suggested to follow up at the OST center and restart the treatment at the earliest convenient date . The attendance frequency in the following 1 month after the tele psychiatry session was assessed and analyzed. RESULTS Twenty-eight out of 32 clients approached the OST center within 3 days of the home visit session and 22 clients remained in treatment until 1 month period following the intervention. Most common reason for leaving the treatment was logistic problems. Twenty nine clients were using some form of substance, alcohol being the most common; 18 reported to be using their substance of choice: heroin.

No. 10
Where They Are: A Web-Based Mapping Tool That Synthesizes Public Datasets for Clinicians to Better Understand Patients' Extra-Clinical Settings
Poster Presenter: Walter Mathis, M.D.

SUMMARY:
In recent years, a growing body of literature has validated the intuitive notion that where one lives affects one's health. Factors ranging from household income to the age of housing stock have been shown to influence physical or mental well-being -- the social determinants of health. But, clinicians face major hurdles to incorporating these findings into clinical care. For instance, while enormous amounts of geographically coded socio-economic and built environment data are available online for free, they are spread across various federal, state, and local agencies in different formats. Collecting and synthesizing these disparate data is beyond the technical and time constraints of most clinicians. This poster explores a web-based mapping tool that was developed to facilitate exploration of diverse public data sets to help clinicians better understand their patients' settings outside the clinic, informing their formulations and intervention strategies.

No. 11
Providing Psychiatric Care to a Young Person at a Comprehensive Youth Center in an Urban Setting
Poster Presenter: Mary Conlon, M.D.

SUMMARY:
Ms. S., a 23-year-old African-American female, comes to a comprehensive youth center to enroll in

a college readiness program. She has a high school degree, currently lives with her mother, and received special education services in the past but no prior mental health treatment. Soon after she starts the program, she becomes very attached to the main teacher. There are concerns about her ability to maintain appropriate boundaries and Ms. S. is referred for counseling at the youth center. It is then discovered that she has a history of sexual abuse by her brother with significant depressive, anxiety, and Post-Traumatic Stress Disorder symptoms. She is referred to the psychiatrist for medication management and ongoing therapy. She responds incredibly well to treatment with an SSRI and cognitive behavioral therapy. She is able to maintain appropriate boundaries with staff members, has resolution of her depressive symptoms, is able to work increased hours, and enter a romantic relationship. She reflects back on prior depressive episode in high school and how earlier treatment would have perhaps changed some of her trajectory. She is thankful for the current treatment and is hopeful about her future as she contemplates various job programs and returning to school. Comprehensive youth centers that offer a wide variety of services including health care, education, mental health treatment, career development, recreational activities, and job support, all for free and completely confidential are unique places that can meet the needs of many youth, particularly those that may be disenfranchised and have little other supports. They are also excellent places to provide mental health care and psychiatric services as they draw young people that are in need of care but perhaps would not seek it elsewhere. The additional services they offer also supplement the more traditional counseling and psychiatric services to best serve the needs of the entire young person and their health and well-being.

No. 12

A Grassroots Approach to Mental Health Community Engagement and Education

Poster Presenter: Carlos Fernandez

SUMMARY:

Background: Reducing disparities in mental health has become a national priority. Minority groups underutilize and often are apprehensive when accessing mental health services. As a result, a significant number of children with behavioral health issues go without diagnosis and treatment; frequently leading to potentially negative outcomes. The UCLA -Kern Medical, Child and Adolescent Fellowship Program has identified these alarming trends and initiated a grassroots community academic partnership educational campaign focusing on educating community members. The research study will provide mental health education promoting stigma reduction, clarifications of mental health misconceptions and instilling positive attitudes toward children's mental health issues. Methods: A pilot study will be carried out at several community centers in Kern County, with a population made up of greater than 52% Latino. The study population will be volunteer community members interested in learning about children's mental health. They will be provided two separate educational lectures focusing on attention deficit/hyperactivity disorder and depression. Literacy scales will be used in a pre and post survey to assess general mental health knowledge, stigmatizing attitudes, locating mental health referral information, treatment modalities, recognition of common mental health conditions in children, and knowledge about children's mental health well-being. At the completion of data gathering, the study will incorporate final data collection and statistical analysis to determine possible correlations. This time frame will be in line with the American Psychiatric Association SAMHSA Minority Fellowship (July 2016-June 2018). Results: The pilot study's primary focus is to increase the communities knowledge concerning children's mental health. The use of a community academic partnership will aim to reduce stigmatizing attitudes, allow participants to become informed members of their community and recognize common mental health conditions in the child population. We anticipate that during the course of the study participants will learn how to access mental health services, become familiar with different treatment modalities and develop an increase awareness for children's mental health conditions. Conclusions: Reducing mental health barriers and eliminating disparities is crucial in empowering patients and families. By utilizing a community academic

partnership model, the objective of the study is to inform community members about children's mental health conditions, reduce stigmatizing attitudes in under resourced communities, and increase community mental health literacy. The UCLA -Kern Medical, Child and Adolescent Fellowship Program, intends to help identify early signs and symptoms of mental health conditions for early prevention, intervention and treatment of children within Kern County.

No. 13

Protective Effects of Social Support Networks Against Posttraumatic Stress Disorder and Alcohol Abuse Following Disaster Exposure

Poster Presenter: Robert Fuchs
Co-Authors: Howard J. Osofsky, M.D., Ph.D., Tonya Hansel, Joy D. Osofsky, Ph.D.

SUMMARY:
Background: Many adolescents in New Orleans have had repeated exposure to major disasters due to the devastating effects of Hurricane Katrina (HK) in 2005 and the Deepwater Horizon Oil Spill (OS) in 2010. Each of these occurrences have elicited symptoms related to posttraumatic stress disorder (PTSD), depression, generalized anxiety disorder, and alcohol abuse. The symptoms of these disorders have persisted more than ten years after the first of these two disasters took place, reflecting the strong influence that HK and OS have had on the Louisiana population. Our group previously examined the relationship between the severity of exposure to these events and the degree of alcohol use and PTSD symptoms, and we found that children who were more directly exposed to these disasters developed more severe alcohol abuse and PTSD symptoms during adolescents relative to children who had less disaster exposure. Despite this important finding, the protective effects of social support systems such as family intimacy and engagement in extracurricular activities have not been investigated. Methods: High schools in southeastern Louisiana's Saint Bernard Parish administered a survey, the LSUHSC Department of Psychiatry Disaster Interview, to students who had experienced both HK and OS as children. Data were analyzed from over 400 adolescents aged 14-18. The questions on the survey asked for self-report data on the level of alcohol use and PTSD symptoms such as anxiety and depression. The subjects' social experiences were also assessed by asking about engagement in hobbies and school clubs and interest groups. Results: We will use SPSS to generate logistic and multiple regressions and assess the degree to which engagement with a social network influences adolescent alcohol use and PTSD symptoms. Based on existing literature, it is anticipated that an increased level of social engagement will be inversely correlated with PTSD and alcohol use. These findings will describe critical insight by assessing the value of socially-oriented mental health services in communities subjected to severe stressors or major disasters.

No. 14

Work Motivation Among Mental Health Nurses in a Public Psychiatric Hospital in Lagos, Nigeria

Poster Presenter: Abosede Adekeji Adegbohun, M.B.B.S.
Co-Authors: Increase I. Adeosun, M.B.B.S., Richard Ademola Adebayo, M.B.Ch.B.

SUMMARY:
There is a growing body of literature that has attributed the quality of services rendered by health personnel to the degree of their work motivation. There is however dearth of information on the extent of work motivation of mental health nurses in Sub-Saharan Africa. This study assessed the level of work motivation among this cadre of workforce working in a public psychiatric hospital in Nigeria. The factors contributory to their level of work motivation were also assessed. Methods: The study was conducted among mental health nurses of the Federal Neuropsychiatric Hospital Yaba, Lagos, Nigeria. The level of work motivation and the factors contributory to the work motivation of 86 mental health nurses were assessed over a three-month period. Data were analyzed using IBM-SPSS version 20. Results: The mean age of the participants was 39.90 (±8.66) years. Majority of them were females (73.3%), married (86.0%) while more than half (57%) belonged to the senior cadre of nursing. About 54.7% of the mental health nurses were motivated with their job. The participants' scores on the motivation scale ranged from 81 to 119 with a mean score of 98.71±7.94. The highest mean scores were recorded on the job characteristics and career

development subscales while the lowest mean score was recorded on the recognition subscale. At least a B.SC degree in nursing was a strong motivational factor among the study participants. Conclusions: The findings from this study support previous findings. There is need to strengthen management capacities in mental health services in Nigeria with the aim of increasing the work motivation of mental health nurses in public settings. Keywords: Work motivation, motivational factor, mental health nurses, public psychiatric hospital

No. 15

Perception of the Quality of Service and Level of Satisfaction Among Outpatients in a Psychiatric Hospital Setting

Poster Presenter: Gbonjubola Omorinsola Babalola, M.M.P., M.B.B.S.
Co-Authors: Abosede Adekeji Adegbohun, M.B.B.S., Oyewale Alfred Ogunlowo, M.B.B.S., Suraju Adeyemo, M.B.B.S., Adebayo O. Jejeloye, M.B.B.S., Adunola A. Pedro, M.B.B.S., Olufemi Oyekunle, Ayodeji A. Bioku, M.B.B.S.

SUMMARY:
BACKGROUND: In recent times, research has focused on the extent of patients' satisfaction and quality of services rendered in healthcare facilities as indicators of effective healthcare systems. These are useful information necessary for the development of programs targeted at improving the overall services rendered within the healthcare settings. There is however limited research work on this subject in Sub-Saharan African setting. OBJECTIVE: This study assessed the quality of care received and the level of satisfaction of patients attending the outpatient department of a public mental health institution in Nigeria. METHODOLOGY: Using a non-probability, convenience sampling method, the level of satisfaction and the perceived quality of care received by one hundred patients that assessed the out-patient clinic of Federal Neuropsychiatric hospital Yaba were determined. The data were collected with the use of socio-demographic questionnaire as well as a modified survey questionnaire. The data were analyzed using IBM-SPSS version 20. RESULTS: The mean age of respondents was 40.02 ± S.D 10.93 years. The highest mean score for satisfaction was on the overall quality of care 8.40 ±1.63. About 73% of the respondents adjudged the quality of services received as good. Participants that had lower level of education were more likely to perceive the quality of care received as good. Eight out of ten (80%) of the respondents admitted that they will recommend the service to a family or friend should the need arise. Keywords: Quality of Service, Level of Satisfaction, Outpatients, Hospital setting

No. 16

WITHDRAWN

No. 17

How Are People With Mental Illness Portrayed on TV Crime Shows?

Poster Presenter: Jessica Berthelot, M.D.
Lead Author: Kathleen Crapanzano
Co-Authors: Rebecca Horn, Richard Vath, M.A., Margaret Mitchell, M.B.A.

SUMMARY:
INTRODUCTION People with mental illness face societal stigma, institutional stigma, and even self stigma. These attitudes are influenced by media representations, including the portrayal of TV characters with mental health challenges. Because one common perception of people with mental illness is that they are generally violent, we set out to study the use of words that reference a mental illness on top-rated crime shows to see if they perpetuated that belief. METHODS This study is an observational, retrospective, mixed quantitative and qualitative study evaluating portrayals of mental illness on top ranked criminal primetime television shows. Words representing major mental illness diagnoses, symptomatology, mental health facility/provider keywords, slang/derogatory terms and general terminology were identified from the transcripts of nine dramatic crime series from the 2014 television season. Our team of authors reviewed and categorized each in context as to whether it was used accurately and when inaccurate whether it was a positive or negative usage. When the transcript identified a character who appeared to have a mental illness, the transcript was reviewed in more detail to determine the role the character played in the episode. RESULTS After examining the transcripts of 210 episodes from nine highly rated

drama series, 54% of the words that were examined were used inappropriately or in an unprofessional manner, and of those inappropriate usages, 49% were used in a negative manner and directed toward a person. Eight words were determined to be used in a negative manner greater than 90% of the time (nut/nutjob, asylum, lunatic, crazy, deranged, insane/insanity, whacko, shrink). Based on the transcript review, when a character was identified as having a mental illness, the character was portrayed as a perpetrator or suspect almost twice as often as a victim or witness. DISCUSSION We found that the language with mental health implications in popular crime shows were commonly inappropriate and inaccurate. Additionally, a significantly disproportionate number of characters with a mental health issue were portrayed as potential violent criminals. More study on the use of language regarding mental illness and the portrayal of people with mental illness in the media is needed to further explore the effect of this medium on societal views towards mental illness.

No. 18

Building Partnerships: Using a Collaborative Training Module With Psychiatrists and Refugee Case Workers to Better Serve Houston Refugee Families

Poster Presenter: Kristen Guilford
Co-Authors: Kelly Aylsworth, M.D., Ye B. Du, M.D., M.P.H., Sophia Banu, M.D., Diana Prieto

SUMMARY:
Since 1975, the US has welcomed nearly 3.4 million refugees from various regions, with nearly 85,000 accepted in 2015 alone. In this same year, 15,866 of these refugees from 43 countries resettled in Texas, including 6834 who resettled in Harris County, which includes the city of Houston. The Houston metropolitan area is home to multiple resettlement agencies staffed with caseworkers who assist refugee families in navigating the transition to American culture, the health care system, employment, and integration into society. There are numerous factors which create challenges and limit available support for refugees, both in the community and in health care systems throughout the process of resettlement. These factors, compounded with traumatic experiences often endured by refugees, contribute to the mental health burden on refugees. The current literature on educating refugee caseworkers about available mental health resources is limited, as are studies involving collaboration with mental health providers and other health care professionals. This project describes a collaborative 3-hour training session which involved resettlement agency case workers, case managers, psychiatrists, and psychologists who work with refugees in Houston, TX. Goals of this training session included facilitating discussion and collaborative problem solving to address common challenges, to maximize awareness and utilization of available services provided to refugees by participants of the training, and to strengthen partnerships between providers of services for refugees. The training format began with a group icebreaker, followed by small group case-based discussions and process groups, an experiential mindfulness exercise, a large group discussion on burnout in the context of working with refugees and concluded with a discussion of self-care and stress management skills. Outcomes included strengthening of the partnership between local resettlement agency case workers and mental health providers, clarification of roles of case workers, case managers, and mental health providers, increased knowledge of available community resources for refugees as well as case workers, improved ability to screen for mental health issues and effectively refer refugees to appropriate mental health services when needed. Future directions of study include conducting a needs assessment of resettlement agency staff to refine focus of training objectives in future modules, as well as expanding this training modality to include health care provider in specialties outside mental health.

No. 19

Mental Health Among Coptic Christians: Barriers and Novel Approaches

Poster Presenter: Mena Mirhom, M.D.

SUMMARY:
Although Coptic Christians, who are the largest Christian population of the middle east, constitute a significant presence in North America, their utilization of mental health services remains fairly low. There are cultural and perceived religious

prohibitions that hinder access to mental health services. The shame and stigma in the community is, at times, overwhelming. Lack of insight, language barriers, and financial hardship also prove to be significant barriers. In this poster, we discuss a novel approach of a free mental health clinic where a Coptic priest, who is also a licensed psychiatrist, is the primary mental health provider. We will discuss demographic data of the clinic, treatment approaches and outcome measurements of the past 5 years.

No. 20

Triple Diagnosis: HIV Infection, Substance Abuse, and Psychiatric Disorders

Poster Presenter: Rahn Kennedy Bailey, M.D.
Co-Author: Afrayem Morgan

SUMMARY:
Patients with serious mental illness (SMI) have higher rates of HIV infection than do individuals in the general population, most likely because of their higher levels of sexual risk behavior and injection drug use. Substance use is associated with increased sexual risk behavior, poorer health outcomes in individuals with HIV, poorer HAART adherence, decreased health care utilization, and poorer immunologic and virologic outcomes. Management of triple diagnosis is in need of concensus clinical guidelines, including a preventive perspective and a model of integrated HIV treatment. The primary modalities of substance abuse treatment models in persons living with HIV include cognitive behavioral therapy, social support/support group models, motivational enhancement/motivational interviewing, transtheoretical frameworks, and directly observed therapy. It is recommended that integrated care systems must also serve as a portal to address issues such as sexual risk, self-care, and adherence. HIV testing and prevention messages should be standard of care in substance abuse treatment programs. Existing models of psychotherapy and substance abuse treatment require contextualizing. Research agendas should focus on the use of technology.

No. 21

"I Wanted Help Then… Not Anymore": Treatment Issues in a Patient With AIDS and Cocaine Use

Poster Presenter: Catalina Trevino Saenz, M.D.
Co-Authors: Sina Shah-Hosseini, M.D., M.S.E., Raj Addepalli

SUMMARY:
This is the case of a 53-year-old African American woman, homeless, with a psychiatric history of stimulant use disorder (cocaine), prescription opiate use disorder, self-reported depressed mood, Medical history of AIDS, Hepatitis C, Herpes Zoster, Anorectal cancer s/p radiation, Laryngeal cancer s/p laryngeal surgery and partial tongue graft, who presented to the Psychiatric Emergency Services complaining of suicidal ideation. Patient reported history of daily cocaine use, non-adherence to HAART and home psychiatric medications which included Mirtazapine 30 mg by mouth. Upon admission to the inpatient unit the patient was restarted on Remeron 30 mg at night time and presenting symptoms began to resolve on second inpatient hospital day. Patient had history of similar initial presentation requesting referral to detox/rehabilitations services followed by a refusal to follow through on referral to an inpatient drug rehab program. She also did not follow up repeatedly with HAART treatment and had a CD4 count of 1 and a exponentially high viral load and was also diverting HAART medications to support her drug use. Patient had history of repeatedly presenting to the hospital in an emaciated, frail, apathetic state reporting chronic pain and reporting suicidal ideation after cocaine use. Extensive psychoeducation and motivational interviewing failed to convince the patient in following through with substance abuse treatment, housing referral and referral to a specialized residential treatment facility for patients with AIDS and comorbid substance abuse. Pt constantly rejected referral indicating that she was not ready to stop using illicit substances and she would consider it in the future. Repeated pleas to at least consider harm reduction strategies failed to enthuse the patient to commit to any referrals in the community. This case highlights the difficulty of treating comorbid substance use along with AIDS when coexisting homelessness and absence of a supportive network hampers attempts to recovery and sustaining wellness in the community. Effective treatment may require engagement of the patient with outreach teams who will target the patient with multiple encounters in

the community with modest goals of using treatment as at least a period of abstinence when a wellness checkup can be performed and medical issues can be uses as a starting point to reengage the patient in treatment. Respect for patient autonomy in making decisions and absence of a legal mandate to force patients with comorbid substance use and AIDS unlike assisted outpatient psychiatric treatment can frustrate providers who are concerned about the progressive decline in physical health of these patients.

No. 22

Readmission Reduction Strategies at a Regional Academic Medical Center

Poster Presenter: Seema Sannesy, M.D.
Co-Authors: Stephen Ferrando, M.D., Eva Carmona, M.H.A., Hal Smith, M.P.S., Rachel Zinns, M.D.

SUMMARY:
Repeated psychiatric hospitalization, primarily for those with serious mental illness, continues to be a problem nationally. While much focus has been given to finding the balance between length of stay (LOS) and 30-day readmission rate, the factors that influence readmission rates appear to be multiple. Identifiable reasons for psychiatric readmission include, but are not limited to, history of previous admission, premature discharge, inadequate transition support services after discharge, nonadherence with aftercare and/or medications, or simply discharge plan failure. In efforts to reduce 30-day inpatient psychiatric readmissions a regional academic medical center in New York State's Hudson Valley has employed a number of strategies. Integral to this initiative has been joining the Readmissions Quality Collaborative (RQC) sponsored by the NYS Office of Mental Health, the Healthcare Association of NYS, and the Greater NY Hospital Association, along with formation of a multidisciplinary Behavioral Health Readmissions Reduction Committee within the medical center. Baseline data analysis of readmissions included the examined variables of LOS, reason for readmission, discharge referral, and whether initial aftercare appointment was kept. Quarterly analyses have been completed as various readmission reduction strategies were employed over time. These strategies thus far have included introduction of a readmission risk assessment form to be completed at the time of intake, Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) access for clinicians, warm handoffs prior to discharge, bedside prescription delivery, a single organized folder provided to patients at the time of discharge containing discharge and aftercare instructions, an outlined readmission reduction plan as part of discharge documentation, post discharge follow-up calls to patients and outreach calls to aftercare providers, and introduction of a social worker/care manager in the psychiatric emergency department setting to facilitate short-term alternatives to psychiatric hospitalization. These strategies are presented and evaluated with regards to their effects on quarterly data analysis of readmission rates, along with specific barriers noted.

No. 23

The Alzheimer's Prevention Initiative Generation Study: A Preclinical Trial in APOE4 Homozygotes

Poster Presenter: Pierre N. Tariot, M.D.
Co-Authors: Jessica Langbaum, Ph.D., Fonda Liu, Pharm.D., Marie-Emmanuelle Riviere, Ph.D., Ronald G. Thomas, Ph.D., Robert Lenz, M.D., Gabriel Vargas, M.D., Ph.D., Angelika Caputo, Ph.D., Ana Graf, M.D., Cristina Lopez-Lopez, Eric Reiman, M.D.

SUMMARY:
Background: The Alzheimer's Prevention Initiative (API) was established to evaluate preclinical Alzheimer's disease (AD) treatments in cognitively unimpaired people who, based on age and genetic background, are at imminent risk for developing symptoms of AD. The API APOE4 Trial, also known as the Generation Study, is evaluating the effects of two amyloid targeted therapies (CAD106 and CNP520) in cognitively normal people who, on the basis of age and being apolipoprotein (APOE) E4 allele homozygotes, are at particularly elevated risk of developing symptoms of AD. CAD106 is an active immunotherapy against Aß; CNP520 is a Beta-site-APP cleaving enzyme-1 inhibitor. We hypothesize that Aß-lowering therapies might be most effective in the preclinical stages of AD, prior to development of extensive pathology. Identification of APOE4 homozygotes is employed as a prognostic enrichment strategy to select individuals likely to show cognitive decline in the near future. APOE4

homozygotes are at elevated risk of developing symptoms of late-onset AD: by age 85, the risk of symptomatic AD reaches 51% for male homozygotes and 60-68% for female homozygotes (Genin et al., 2011). About 70-80% of APOE4 homozygotes age 60-75 will have extensive fibrillar Aß deposition (Jansen et al., 2015). Methods: Under the auspices of the Alzheimer's Prevention Registry, we developed a novel, trial-independent APOE recruitment registry known as GeneMatch to support enrollment into this and other studies. The Generation Study employs two primary outcomes: time to diagnosis of MCI due to AD and decline on the API preclinical composite cognitive (APCC) test. The APCC was developed as a sensitive tool to detect and track cognitive decline in individuals at risk for progression to the clinical stages of AD. The effects of therapy on various biomarkers will be assessed as will the extent to which treatment biomarker effects could predict clinical benefit. Importantly, the impact of disclosing APOE4 genotype and associated risk information to older adults will be assessed. Results: The global trial, funded by NIH, philanthropy and Novartis/Amgen, has just launched. GeneMatch serves as the primary recruitment mechanism in the US; over 40,000 volunteers have been genotyped thus far, of whom nearly 5% are APOE4 homozygotes. APOE4 homozygotes and a random sample of non-homozygotes who consent and appear to meet basic trial eligibility criteria for the Generation study are invited to trial sites for additional screening and disclosure of APOE genotype and associated risk of developing symptoms due to AD. Conclusions: Trial progress to date will be summarized. We anticipate that the GeneMatch program, which will also be summarized, will identify a large pool of prospective participants for the Generation Study and future trials.

No. 24

Assessing the Knowledge and Practice of Clinicians Prescribing Potentially Teratogenic Medications in an Outpatient Clinic

Poster Presenter: Sahil Munjal, M.D.
Co-Authors: Anna Karagkouni, Beth Zell, Ifeoluwa Osewa, Julia Nahmias, Gohar Khosravi

SUMMARY:

Background: Mood stabilizers, benzodiazepines and paroxetine carry a risk for teratogenicity when prescribed to pregnant women. It is thus essential that women of reproductive age receive proper psychoeducation and be on multiple methods of contraception and when prescribed these medications along with the clinician documenting this discussion. We wanted to evaluate the current trends and attitudes of clinicians prescribing potentially teratogenic medications in our outpatient clinic. Methods: We designed a survey and sent it out to our outpatient prescribers with questions on how often they prescribe medications with teratogenic potential to females of reproductive age, how often they educate them about the potential risks to the fetus, about the protective role of folate (for valproate and carbamazepine), how often they inquire about pregnancy status and birth control methods and finally we included a few questions to evaluate their knowledge about the medications' reproductive side effects. We also conducted a chart review and identified 79 charts of women of reproductive age who have been prescribed at least one of the these medications in the past year (Dec 2015-2016) and collected data regarding how often prescribers documented that they educated their patients about the reproductive risks, inquired about birth control method or possible pregnancy or tested for pregnancy. Results: 9 providers participated in our survey. All of them were treating females of reproductive age and 7 of them (77.8%) indicated that they prescribe to them FDA pregnancy category D or X medications. The vast majority of providers (88.8%) indicated that they have educated their patients about the risks at least once (and 44.4% of them indicate that they document this at least every 3 months) and they have inquired about birth control methods at least once. 50% of the providers ask about possible pregnancy only the first time they prescribe or do not ask at all, while 77.8% do not check HCG. More than half (55.6%) discuss the protective role of folate. Regarding providers' knowledge about medication side effects, all of them were aware of lithium, but things are not as clear when it comes to benzodiazepines or topiramate. Chart review results: In 9/79 charts (11%) it was documented that patients were educated regarding reproductive risks, in 9/79 charts (11%) it was documented that providers inquired about birth control method, in 3/79 charts (4%) HCG testing was

documented and in 10/79 charts (13%) it was documented that providers inquired about possible pregnancy. Conclusion: The clinicians' knowledge regarding the reproductive risks of certain psychiatric medications appears to be fair, however, monitoring for possible pregnancy is not as good. All documentation regarding the aforementioned issues has been poor. Our next step is to educate the clinicians regarding our current practice, monitor and track the charts for these discussions.

No. 25

A Framework to Survive and Prosper in a Psychiatric Collaborative Care Setting

Poster Presenter: Vikram N. Shah, M.D., M.B.A.
Co-Author: William Lopez, M.D.

SUMMARY:
The psychiatric collaborative care model (CoCM) was developed by the late Wayne Keaton, M.D. and JÃ¼rgen UnÃ¼tzer, M.D., M.P.H., M. A. at the Advancing Integrated Mental Health Solutions (AIMS) center at the University of Washington. It is an evidenced based model and has proved effective in numerous randomized controlled trials. In the psychiatric collaborative care model, the primary care physician employs a behavioral care manager to provide care management for a caseload of patients with diagnosed mental health or substance abuse disorders. The psychiatrist provides expert advice to the primary care physician. The psychiatrist provides recommendation for the treatment plan and has weekly consultation rounds with the behavioral care manager. If necessary, the psychiatrist assumes treatment for difficult cases. Starting January 1, 2017, Centers for Medicare and Medicaid Services (CMS) began reimbursement for psychiatric collaborative care services. CMS has established three new billing codes (G0502, G0503 and G0504) to reimburse care provided under the psychiatric Collaborative Care Model (CoCM). In this poster, we focus on how a psychiatrist in private practice can be involved in a collaborative care model. Opportunities for allied disciplines (social work, psychology, nursing etc.) are discussed as well. We review the evidenced based model that has proved effective in numerous randomized controlled trials. The nitty-gritty details of participation in such a model by a psychiatrist in private practice are discussed. This includes determining and assigning a risk rating for the population, care manager qualification, medical record keeping, obtaining patient consent, financial reimbursement models as well as provision for addressing crises situations. CMS billing codes as well as the 2018 replacement AMA CPT Codes (if available) are reviewed. Established collaborative care programs such as the Mental Health Integration Program in Washington State and the DIAMOND program in the State of Minnesota are reviewed as well.

No. 26

Disruptive Mood Dysregulation Disorder: A Unique Pediatric Neuropsychopharmacological Approach

Poster Presenter: Daniel T. Matthews, M.D.
Co-Author: Glenda W. Matthews, M.D.

SUMMARY:
Background: The DSM-5 (296.99)(ICD-10 F34.81) diagnosis of Disruptive Mood Dysregulation Disorder (DMDD) has minimal research available exploring psychopharmacological approaches addressing the hallmark symptoms of severe, recurrent temper outbursts and persistent irritability that occur, on average, three or more times per week, over a period of one year. Recently published studies, resultant from applying the official DSM 5 criteria to large community based mental health populations; indicate three month prevalence rates of 3.3% to 8.2%. When treated with the currently applied medication protocols, these studies indicate a poor long term functional prognosis. Objective: Our current study explores the feasibility of more effectively managing DMDD symptomatology with a unique medication protocol. The primary components include the combination of an anticonvulsant to target mood lability and anger outbursts and a dopamine agonist to target impulsivity, irritability, and concentration. Method: Subjects were 91 persistently irritable and explosive children and adolescents (52 male, 39 female, ages 6-17) with previous inpatient treatment for primary diagnoses of bipolar disorder, other unspecified mood disorder, and oppositional defiant disorder. Upon retrospective chart review, all subjects met the diagnostic criteria for DMDD. All subjects were discharged on a pharmacological combination of an anticonvulsant (oxcarbazepine, target dose range 35-

50 mg/kg/day) and amantadine HCl (target dose range of 10-15 mg/kg/day). Utilization of antipsychotic medications was minimal to none. Outpatient providers were supplied with a compendium of research articles and information regarding the unique pharmacological approach, and requested to comply with the approach, based on their assessment of the patients' ongoing outpatient clinical presentation. As a result of parent/caregiver surveys one year post discharge, providers were grouped into compliant (maintained the protocol with minimal to no adjustment), or non-compliant (discontinued the protocol, often substituting antipsychotic medications). Results: The percent of re-hospitalization for uncontrolled aggression at one year post discharge was calculated separately for those subjects whose aftercare providers were, or were not, compliant with the protocol. For the fully compliant, 8% (5 of 64) required re-hospitalization. For the non-compliant providers, 26% (7 of 27), required re-hospitalization. Using Chi-square analysis, there was a significant relationship between re-hospitalization rates and compliance to the pharmacological protocol (Chi-square, two tailed with Yates = 3.975; P<.05; Phi = .24. Conclusion: The results indicate that, for children and adolescents one year post inpatient discharge for diagnosis of DMDD (retrospective), continuation of the descried unique medication protocol provides significantly lower rates of re-hospitalization. Further controlled studies are needed.

No. 27

Predictors of Seclusion and Restraints in an Inpatient Pediatric Psychiatric Hospital: A Retrospective Chart Review

Poster Presenter: Marwa Badawy, M.D.

SUMMARY:

Seclusion and restraints (S&R) in child and adolescent psychiatric hospitals are often used to maintain the safety of the patient and others on the unit. The prolonged use of S&R has been found to have negative consequences, both physical and psychological, and has not been shown to be effective. S&R use is highly regulated and is only used in extreme circumstances when there is an imminent risk of harm to patient or others. There is a paucity of research on S&R use in the pediatric psychiatric inpatient population. Most research currently discusses the harmful effects of S&R use and alternative strategies for reducing its need. This study aims to find a correlation between certain risk factors and S&R use in the child and adolescent psychiatric inpatient unit. The main aim is to try and look at predictors of those who might be at higher risk for S & R events and early identification of these patients and working on an effective treatment plan to prevent S&R events. A retrospective analysis of children and adolescents admitted to Missouri Psychiatric Center at University of Missouri from July 2009 to December 2012 was conducted to examine predictors of S&R use. After IRB approval was obtained, patients (N = 120) with at least one seclusion or restraint event (N = 159) were identified. An extensive chart review through electronic medical records was conducted and the specific data needed for this study was gathered and included in a database. The Chronic Behavioral and Affective Dysregulation Syndrome (CBADS) questionnaire was created to assess risk factors in the subset of patients who had an S & R event. With the help of this instrument several demographic and historical clinical variables were collected including reason for admission, treatment history, placement history, self-harm history, suicide attempts, aggression history, substance use history, abuse history, in addition to other psycho social variables. Additionally, every seclusion and restraint incident was documented with cause, type of restrictive measure(s), length of time, and any medication(s) that were administered. Data will be analyzed for descriptive statistics and to look at any correlation of risk factors on CBADS to S & R events. Since there is limited research and data available regarding restrictive interventions, more research is necessary to determine whether findings observed are universally applicable. Understanding risk factors for S&R use in the pediatric population will diminish its need and ameliorate safety.

No. 28

Official Translation of CRAFFT in Korean and Small-Scale Accuracy Assessment

Poster Presenter: Ah Lahm Shin, M.D.
Co-Authors: Jung W. Kim, M.D., John Rogers Knight, M.D., Patricia Schram, M.D.

SUMMARY:
Background: Since its first introduction in 1999, CRAFFT has become a standard of care screening tool for substance use among adolescent and young adults. CRAFFT has been translated into more than 20 different languages, but there has not been an official translation version in Korean. Boston Children's Hospital sets quality standards for the accuracy of language translations and cultural adaptations. Our goal in this project is to provide the first official Korean translation version and attempt to assess its usability in a small-scale study. Methods: Two bilingual medical doctors, who are fluent in both Korean and English, translated the CRAFFT English version into Korean. One of the translators was in his final year of child and adolescent psychiatry training and had more than four years of practice in psychiatry. The other translator did not have any official training in psychiatry but had knowledge of CRAFFT through medical school education. Three non-medical bilingual Koreans, whose primary language was Korean, then back-translated the Korean translation into English. The project investigators then compared the original English and back-translation versions to assess the accuracy of the translation and the understanding of linguistic and cultural nuances by non-medical persons. Results: Preliminary cross-comparison shows that our Korean translation version was accurate, well understood by non-medical bilinguals and adequately accommodated the linguistic and cultural nuances. Conclusion: In our paper, we first present an official Korean version of CRAFFT that is linguistically accurate, understandable to non-medical Korean bilinguals, and culturally appropriate. This Korean version is to be publically available through the Boston Children's Hospital website.

No. 29
WITHDRAWN

No. 30
The Cultural Genogram Revisited: Finding a Path to Ensure Patient-Centered Cultural Formulation and Promote Effective Mental Health Education and Care
Poster Presenter: Uri Meller, M.D.
Co-Author: Madeleine S. Abrams, L.C.S.W.

SUMMARY:
Culture, “the integrated pattern of human knowledge, belief, and behavior that depends upon the capacity for learning and transmitting knowledge to succeeding generation is a dynamic, ever changing, evolving, and elusive concept, that is dependent on time, space and subjective experience.” Both health care staff and students have greatly benefited from the curriculum of cultural competency, and curiosity about individual cultural experiences. Through their clinical experience with the culturally diverse population of the Bronx and through their teaching of medical students and psychiatry residents at Albert Einstein College of Medicine, the authors propose a well-documented individual and family centered approach for formulating culture via use of cultural genograms. The genogram is the story of a family over many generations. In constructing the cultural genogram, the therapist and patient/family can explore together the richness of the family and the individual’s history including migration and immigration, race, ethnicity, religion, gender identity values and expectations, socioeconomic class, and experiences of power and oppression. The process is humanizing, enriching, and a way of opening dialogues about central themes which might not be discovered if discussion were limited to the individual’s focus. In the poster presentation, theoretical ground work to support this approach will be provided, as well as clinical vignettes and genograms to demonstrate its utility. Further discussions will emphasize the benefits of utilizing “the patient as an educator” approach. Clinical examples utilizing this conceptual framework and methods will demonstrate impact on access and effectiveness of care in a diverse population, as well as on training clinicians in teaching institutions. We will consider ethical implications as well as the value of these techniques in medical education, in the context of a growing content rather than process oriented care.

Poster Session 3

No. 1
Delusional Parasitosis: A Literature Review and Case Report

Poster Presenter: Allen Dsouza, M.D.
Co-Authors: Ghulam Khan, M.D., M.B.B.S., Veeraraghavan J. Iyer

SUMMARY:
Delusional parasitosis is a false, firm belief that some parasite has infested their body. It is a rare disease and is seen in 2.37-17/million/ year. The approximate male to female ratio is 1:3. It can be seen after adolescence in young adults or elderly people. The peak age being 40-60 years. We present a Case report of a Patient who presented with Delusional parasitosis and was treated with Risperidone. Case Report: Patient is 56 year old female with a history of Anxiety Disorder who presented with complaints "parasites are running around my head" and constant itching over her scalp and other exposed parts of her body. She reported that she noticed "a white looking translucent parasite running around her scalp." She also reported calling exterminators into her house multiple times with no success. She reported feeling significant distress because multiple dermatologists and ER visits. She underwent skin biopsies , used skin lotions, topical creams and antihistaminics with no relief. Physical examination showed bald patches on the scalp, multiple lesions over her arms, legs, neck and back which resemble two point scabs. Dermatology team evaluation had no significant findings and referred the patient to the Psychiatry team for Diagnosis of Delusional Parasitosis. Medical work up showed no significant findings. She was started on Risperidone 0.5 mg twice a day and dose was uptitrated to 2 mg twice a day. Patient gained some insight into her illness and was followed up out patient. Follow up evaluation over months showed significant improvement in her condition. Discussion: Patients with Delusional Parasitosis are often evaluated by a number of physicians in the past. Patients describe a crawling sensation or pruritis as the first evidence of infestation. A pathognomonic sign is the "matchbox sign" wherein patients usually bring bottles, bits of skin, lint or tissue as "specimens' to prove the existence of the parasite. They may present with skin lesions often caused by self inflicted injuries with a probable effort to remove the parasite by scratching, skin picking, use of needles, knives or finger nails. These patients are usually reluctant to seek Psychiatric care or referral. Literature recommends ruling out true organic skin disorder, empathic listening ,asking the patient how the condition affects the patient's life, referring the patient to a psychiatrist and starting antipsychotics as ways to approach the case. Pimozide was the drug of choice for treatment however because of its side effect profile it has made way for second generation antipsychotics as drug of choice. Risperdone and Olanzapine have shown good efficacy in treatment of Delusional Parasitosis. Conclusion: Patients with Delusional Parasitosis might come across as rigid and difficult. Team work, building trust and rapport with the patient, use of antipsychotics can be helpful. Psychotherapy can benefit with reducing anxiety and self mutilating behaviors.

No. 2
Treatment Strategies for Negative Symptoms in Schizophrenia
Poster Presenter: Ganesh Kudva Kundadak, M.D.

SUMMARY:
Negative symptoms represent some of the most treatment-resistant and debilitating symptoms of schizophrenia, and contribute substantially to the social and economic burden of the illness. Mental Health Services often struggle to help patients afflicted with negative symptoms, which persist long after positive symptoms have been remedied. In this poster, we shall critically review the existing literature to appraise the available pharmacological and non-pharmacological treatments for negative symptoms. In so doing, we hope to formulate a potential treatment plan for such patients. In our review, we found that pharamcological agents like memantine and oxytocin may significantly improve social functioning, antipsychotics like amisulpride are useful in addressing negative symptoms, and cognitive therapy has a role in alleviating avolition and apathy. Our conclusion is that, whilst more research is required on the subject, an ideal course of action would involve a combination of antipsychotics such as amisulpiride or olanzapine, with a promptly instituted and comprehensive occupational therapy programme.

No. 3
The Clinical (Mis)Diagnosis of Schizophrenia in African Americans

Poster Presenter: Robert Daniel La Bril, M.D., M.Div.

SUMMARY:
Background: It has been acknowledged for at least 50 years that African American (AA) patients are significantly more likely than non-Latino/a White (nLW) patients to be clinically diagnosed with schizophrenia (SCZ). Search Methods: The following data bases from 1960 to November 29, 2016: PubMed MEDLINE, PsycINFO, and Web of Science using multiple combinations of the following MeSH terms; African American (AA), African Continental Ancestry Group, Diagnosis, SCZ. To capture additional articles, the Journal of the National Medical Association was hand-searched from 1960-2016 in addition to scanning reference lists of eight articles. Finally, consultation with an expert in the field was made to identify additional articles. Selection Criteria: Articles were selected if they were published in English between1960-2016; peer reviewed, included AA patients having a diagnosis of SCZ or described AA symptoms of SCZ . Data Collection and Analysis: Two review authors screened abstracts to determine relevance, those deemed relevant received full paper reviews. Any disagreements were resolved by discussion. If no agreement was reached, then a third author made the final decision. Provisional Results: After reviewing 856 articles and approximately 124 full-text papers, 100 articles were included. Inter-rater agreement was .864, indicating a strong level of agreement . The next steps of the scoping review are to: (1) describe publication frequency from 1960-2016; (2)record publication type, hospital settings, study designs, age groups studied, presence of comparison groups, studies showing (or not) a higher proportion of AAs, compared to nLW Americans, diagnosed with SCZ, where appropriate, level of agreement between a clinical and research diagnosis; and (3) list hypotheses employed to explain why AA patients receive a diagnosis of SCZ at higher frequencies than nLW. Provisional Conclusions: The number of articles produced per year steadily increased from the 1960s to the 1980s. Articles steeply increased from the 1990s to the early 2000s and have decreased since then. Most studies argue that AA with mood disorders are misdiagnosed as having SCZ but the absence of an accepted "gold standard" further complicates this conclusion. The extent to which patient characteristics (i.e. differences in symptom presentation, co-morbid mental illnesses, help seeking behavior, cultural mistrust, genetic predispositions, epigenetic influences) and factors influencing the clinical diagnostic process (i.e. ethnocentrism, explicit and implicit bias, clinical uncertainty, rating of patient symptoms, cultural differences, DSM criteria, hospital type, protocols, and location) remain unclear. More research is needed to more clearly document the reasons for higher rates of diagnosed SCZ for AAs compared to nLWs.

No. 4

Motivational Interviewing for Chronic Psychiatric Patients Who Experienced Weight Gain and Metabolic Syndrome

Poster Presenter: Lidia Klepacz, M.D.
Co-Authors: Elizabeth Leung, Annie Xu, M.D.

SUMMARY:
Non-adherence to antipsychotic medication is highly prevalent in patients with chronic schizophrenia and other psychotic spectrum disorders. Non-adherence in this population has been a major obstacle to long-term maintenance treatment and contributing to high relapse rates. Studies have shown that patients are not adhering to medications for various reasons; one of the major reasons is due to the significant adverse effect on weight gain and metabolic dysfunction. Atypical antipsychotic medications are first line treatment for schizophrenia, schizoaffective, bipolar and other psychotic spectrum disorders. However, they are notably associated with obesity, other components of metabolic syndrome, diabetes, and cardiovascular disease. Metabolic syndromes are seen in 42.6% of men and 48.5% of women in patients chronically treated with antipsychotic medications according to some studies. Motivational interviewing is a style of patient-centered counselling developed to facilitate change in health-related behaviors. The core principle of the approach is negotiation rather than conflict. Evidence has shown that motivational interviewing is effective in assisting people with substance use to achieve positive result through behavioral changes. In the past decade, motivation interviewing has been applied to focus on patients

on long-term antipsychotic medication who experienced weight gain as a major side effect through adherence therapy focused motivational interviewing, with or without other interventions that facilitates lifestyle changes. However, the nature of the symptoms secondary to the illness has posted a lot of challenges in treatment course. The limited ability to engage comfortably in relationships, coupled with positive symptoms of paranoia, represents a major barrier to treatment adherence and sustained behavior change. On the other hand, negative symptoms cause problems with self-expression, naming and recognizing emotions, and verbalizing thoughts, as well as many other elements of forming and sustaining relationships; and these may hinder the expression of change talk. In this poster, we will review literatures and available studies on the utility and challenges of applying motivational interviewing with or without specific modifications to focus on medication adherence in patients who experience weight gain, obesity, and metabolic syndrome secondary to chronic use of antipsychotic medication.

No. 5

Managing a Patient on Clozapine Who Is Receiving Chemotherapy During Inpatient Psychiatric Admission

Poster Presenter: Pankaj Manocha, M.D.
Lead Author: Luisa Gonzalez
Co-Author: Nikhil Anbarasan

SUMMARY:

Breast cancer is the most common cancer in women, with a lifetime risk of 1 in 8 in the general population1. Literature review indicates that the incidence of cancer in patients with psychiatric illness is equivalent to the general population, but there is a 30% higher case fatality rate from cancer in psychiatric patients2. Several factors including late presentation and poor access to health care are cited as contributing factors. We present one such case of a 50-year- old homeless, unemployed woman, with no family support that was brought to our hospital by police, psychotic and disorganized. The patient was started on Clozapine after failed response to different psychotropic medications for persistent treatment-refractory psychosis with depressed mood. While on the unit patient also underwent routine screening mammography as per United States Preventive Task Force guidelines, which revealed incidental finding of left invasive ductal adenocarcinoma. The patient underwent surgical removal of the tumor and total mastectomy and was started on chemotherapy with agents Cyclophosphamide and Doxorubicin. This case aims to illustrate the challenges faced in managing a patient on Clozapine while receiving chemotherapy. Treatment strategies, medication side effects monitoring, and recommendations will also be discussed.

No. 6

“She’s Not My Sister!”: A Case Report of Capgras Syndrome in a Patient With Schizophrenia and Vascular Dementia

Poster Presenter: Lauren Pengrin, D.O.

SUMMARY:

• The clinical description of the Capgras Syndrome appeared in the literature as early as 1893. In this syndrome, the patient believes that a person, usually a family member, has been replaced by an exact duplicate or imposter and maintains this false belief despite evidence to the contrary. Capgras' syndrome has been reported with various organic disorders, including subarachnoid hemorrhage, and head injury. A patient was admitted to the general medical floor for poorly controlled diabetes. She has a history significant for hypertension, diabetes mellitus and schizophrenia. Psychiatry was consulted to evaluate the patient's psychiatric medications and make recommendations/changes as necessary during her hospitalization. The patient said that she noticed her sister had been replaced by a "double" many months ago and she avoided spending time with her. She denied believing that any other friends or family members were also imposters. The patient has a past psychiatric history of schizophrenia, which developed in her early 20s. She had multiple hospitalizations and has been on many psychotropic medications throughout her life with inconsistent compliance. She was taking haloperidol 10mg PO at bedtime and had been taking this for the past five years. She reports a history of hypertension and diabetes mellitus, though she admits that she does not take her medications as prescribed. She denied substance use now or ever in the past. The patient

denied seizures or traumatic brain injury in the past. On mental status exam, pertinent findings included paranoid delusions regarding her sister and delusions of her sister being replaced with an "imposter look alike." The patient also had some difficulties with memory and attention, and an MMSE score suggested a comorbid diagnosis of dementia. Upon discovering that the patient was suffering from Capgras syndrome, the question was raised if she was also suffering from any organic brain disorders. After discussion with the medical team, brain imaging was ordered, which revealed multiple old cerebral infarcts and severe sclerosis of the vessels. This prompted the medical team to make significant changes to her medications for management of hypertension. The diagnosis of Capgras syndrome also changed the psychiatric treatment plan. The patient was started on clozapine, and the haloperidol was discontinued. The patient's symptoms of psychosis remained very well controlled, and she slowly began to engage with her sister as her treatment continued. The link between Capgras Syndrome and organic brain dysfunction is well established in the literature and when Capgras syndrome is associated with neurodegeneration, there is likely an older age at onset than if it were associated with a non-neurodegenerative disease. This presentation aims to educate the audience about Capgras Syndrome and the link between organic and psychiatric etiologies for psychiatric symptoms.

No. 7

Delusional Infestation in a Patient With Poor Insight Obsession Symptoms

Poster Presenter: Natalia M. H. O. Santos
Co-Authors: Victor Capelo, Leonardo Jesus, Maira Aguiar Werneck, Tatiana Brancalião Silveira, Priscila Zempulski

SUMMARY:
S.R, female, 49 years old, reached dermatology ambulatorial service complaining of "worm eruption" on her skin, six months from current date. Epidermal excoriation was associated to the emerge of this worms. She storage in a box a huge amount of supposed worms, asking for a professional examination of debris. Dermatologist realized that the escoriation was self perpetrated and sent her to psychiatry service. The skin was severely damaged, so the assistants determined psychiatry hospitalization. The pacient also associated the eruption of worms with a supposed "enchanted plate of food" given from a neighbor whom she already had negative thoughts. Besides that, she performed from a long time daily rituals wich envolves cleaning, organization and religious activities. In this episode, she was treated by a multidisciplinary team, received antipsychotic, antidepressive and antihystaminic medication, improving psychotic and obsessive symptoms and yet achieving great cicatrization from skin lesion. We report a pacient with delusional infestation (Ekbom's Syndrome), condition that the sufferer assumes a self-mutilation behaviour (scratching, harming, cutting) in order to eliminate parasites. This syndrome is associated with several psychiatric comorbidities, in this reportes case, previous history of obsessive symptoms that turned into a delusional disorder, somatic type, was identified. Conclusion: observing the complexity of psychopatology and yet the low prevalence of this condition, the study aim is to review literature of this disorder and analyse the psychopatology envolved.

No. 8

Metformin Use for Metabolic Abnormalities and Weight Gain in Adult Patients With Schizophrenia: A Systematic Review

Poster Presenter: Tatiana Brancalião Silveira
Co-Authors: Priscila Zempulski, Maira Aguiar Werneck, Natalia M. H. O. Santos

SUMMARY:
Objective: Metabolic syndrome (MS) and weight gain has been recognized as a risk factor for cardiovascular morbidity and mortality in general population and in patients with severe mental illnesses, like schizophrenia. Using concomitant medications to counteract these adversities may be a rational option. This systematic review examined the effectiveness of metformin (MT) to prevent or treat weight gain and metabolic abnormalities in patients with schizophrenia. Method: Searches in english, spanish and portuguese language in the electronic database PubMed with the keywords: "Schizophrenia OR Psychotic Disorder " AND "Metformin OR Glucophage " AND "Weight Gain OR

Weight Loss OR Body Mass Index OR Metabolic Syndrome OR Metabolic Disease OR Blood Glucose OR Blood Pressure OR Cholesterol OR Tryglicerides" AND "Antipsychotic" were performed. Four metformin randomized controlled clinical trials (RCTs) using placebo in schizophrenic patients using antipsychotics were included in this systematic review. These RCTS were published in english and involved 324 subjects. Results: Metformin was significantly superior to placebo in the primary outcomes measures (body weight, body mass index, fasting glucose) and in the secondary outcomes (fasting insulin, HOMA, waist circumference, waist-hip ratio). Conclusion: This systematic review suggests that adjunctive metformin is an effective, safe, and reasonable choice for antipsychotic-induced weight gain and metabolic abnormalities. For this reason, choosing this particular drug should be considered after a psychosocial intervention it has proven ineffective. Keywords: Schizophrenia; Metformin; Metabolic Syndrome; Weight Gain; Antipsychotic drugs.

No. 9

Fluoxetine-Induced Psychotic Mania: A Case Report

Poster Presenter: Tatiana Brancalião Silveira
Co-Authors: Maira Aguiar Werneck, Priscila Zempulski, Natalia M. H. O. Santos

SUMMARY:

The Major Depressive Disorder (MDD) is considered one of the medical illnesses of most prevalence and severity in our society, with high psychosocial and functional damage. Different pharmacological classes of antidepressants, as selective serotonin reuptake inhibitor (SSRIs), may increase the risk of hypomanic and manic episodes, although its mechanism is not fully elucidated. Such episodes usually happen in patients with bipolar depression, even though, it may occur in patients with unipolar depression. I hereby report a case of a manic episode with psychotic symptoms in a 38-year-old man, with MDD diagnosis made by a non-specialist doctor (general practitioner) characterized by expansive mood, inflated self-esteem, decreased need for sleep, anxiety, hyperactivity, psychomotor agitation, distractibility, racing thoughts, mistic-religious hallucinations, auditory hallucinations and heteroaggressiveness induced by a selective serotonin reuptake inhibitor (Fluoxetine) after 7 days of use. The patient showed full remission of the maniac episode after 2 weeks of the onset of symptoms, after starting treatment in a psychiatric ward. This material provides a reflection on the importance of a continued and assisted pharmacological intervention, including biological, psychological and social aspects of the patient, as well as the risks associated to avoid morbidities.
Keywords: Mood Disorder; Bipolar Disorder; Psychotic Mania; Induced Mania; Fluoxetine.

No. 10

Suicidal Behavior in Schizophrenia Inpatients in the United States, 2002–2012

Poster Presenter: Mehran Taherian
Co-Authors: Rhaisa Dumenigo, Juan D. Oms

SUMMARY:

BACKGROUND Compared to the general population, people with schizophrenia have a more than eight-fold increased risk of suicide. Among people diagnosed with schizophrenia, an estimated 20% to 40% attempt suicide. Identification of risk factors for suicide is a major tactic for predicting and preventing suicide. The aim of the present study was to study the prevalence of, and factors associated with suicidal ideation and suicide attempts among schizophrenia inpatients in the United States between 2002 and 2012. METHODS Data from the Nationwide Inpatient Sample (NIS) hospital discharge database (Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality) for the period 2002-2012 was retrospectively reviewed. All hospitalizations with a primary diagnosis of schizophrenia from the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) were selected for analysis. Suicidal behavior (including suicidal ideation and suicide and self-inflicted injury) was identified using standard ICD-9-CM codes. The Student's t-test was used to compare the mean in continuous variables. Multivariate logistic regression (IBM SPSS 22.0 software) was performed on the schizophrenia cohort with or without suicide. A p-value <0.05 was considered to indicate statistical significance. RESULTS An estimated total of 3,254,554 hospitalizations were identified between 2002 and 2012 (mean± SD age 43.0±13.7, 57.7% male) with a

primary diagnosis of schizophrenia. 49.0% were white followed by 34.3% black. Of all schizophrenia hospitalizations, 323,713 (9.9%) had suicidal behavior (mean± SD age 41.2± 12.2, 61.1% male, 51.2% white). The rate of suicidal ideation was 9.9%, and suicide attempts 0.6% The most common primary payer in schizophrenics with suicidal behavior was Medicare (42.1%) followed by Medicaid (40.7%). Suicidal behavior in schizophrenia patients was associated with a higher comorbidity rate of drug abuse (adjusted odds ratio [OR], 1.36, p<0.001), alcohol abuse (OR, 1.14), tobacco smoking (OR, 1.85), medication nonadherence (OR, 1.29), depression (OR, 2.74), other neurological disorders (OR, 1.27), AIDS (OR, 1.34), obesity (OR, 1.37), hypertension (OR, 1.11), and hypothyroidism (OR, 1.17). CONCLUSION Suicidal behavior was more common among white male schizophrenics with medication nonadherence, and was significantly associated with comorbidities of substance abuse and depression. Thus, identification and active treatment of depression, improving adherence to treatment, and maintaining special attention to patients with comorbid substance use disorders are essential and are likely to reduce the risk of suicidal behavior in schizophrenia.

No. 11

A Literature Review of Deaf Patients With Psychotic Disorders Who Report Auditory Hallucinations

Poster Presenter: Amilcar A. Tirado, M.D., M.B.A.
Co-Author: Marieliz Alonso, M.D.

SUMMARY:

Deafness is not a uniform phenomenon but exists to varying degrees, ranging from profound prelingual deafness, in which the person has had no experience of hearing sound at all (acquired prior to 3 years of age), to restricted hearing only in those frequencies required for verbal communication, to central auditory processing deficits in which a person has the full frequency range of hearing but cannot meaningfully process these sounds (1,2,3). A deaf patient's ability to communicate may be hampered by language dysfluency. The most common cause of language dysfluency in deaf patients is language deprivation due to late and inadequate exposure to American Sign Language (4). Language dysfluency can make it also challenging for health providers and sign interpreters to identify whether a deaf patient is experiencing psychosis as opposed to limitations with communication (5). Very few studies of the deaf psychiatric population exist, and most are descriptive and anecdotal (6). No well-controlled outcome studies of deaf people with psychosis have been conducted (6). There is controversy about the exact nature of auditory-hallucinations reported by prelingually deaf people with psychosis (3,6). When profoundly prelingually deaf people with psychosis report hearing voices, it is unlikely that they are referring to the same experience that hearing people with psychosis have, simply because they do not have the same framework for "hearing" (1). People with schizophrenia who are profoundly deaf from birth do not describe experiences of sound-based "voices" and cannot describe pitch, loudness, or volume characteristics of the "voices". The subvocal articulation hypothesis suggests that auditory-hallucinations result from the misattribution of inner speech to an external locus of control (7). The subvocal hypothesis posits that the form of the hallucination mirrors subvocal thought processes, which in hearing individuals are predominantly speech-based (7). Further research is needed to evaluate deaf people who show greater heterogeneity in how they experience auditory-hallucinations due to individual differences in experience with language and residual hearing (3). Furthermore, there is a lack of brain imaging or experimental studies, and no research has been conducted to compare how "voices" are perceived by those who were born deaf and those who lost their hearing after acquiring speech (7). At the present time, research on deaf psychiatric patients with psychotic disorders is scarce in the scientific literature (6). When deaf psychotic patients report "hearing voices," they undoubtedly are experiencing something. Just what that is however, is not known. Moreover, hearing mental health professionals may have to come to terms with the fact that they most likely will never be able to know that this experience is unknowable, because they do not share deaf phenomenological frames of reference (1).

No. 12

Ketamine Infusion Protocol for Determining Long-Term Effectiveness in the Treatment of Refractory Depression

Poster Presenter: Mah-Rukh W. Anjum
Lead Author: Ranjith D. Chandrasena, M.D.
Co-Authors: Julie D. Handsor, R.P.N., Terri Lariviere, R.P.N., Alex Leonard, B.M.Sc.

SUMMARY:
Ketamine infusion for treatment refractory depression is now considered an innovative treatment & not an experimental approach. The literature however is not clear about the duration & frequency of treatments for improvement and sustaining improvement. Some studies have recommended daily treatments or twice weekly treatments for 3 weeks. Serial ketamine infusion treatments of 0.5 mg/kg twice weekly have been found to be beneficial but literature does not indicate which patients will sustain improvement over a period of time as well as there is no clarity on treatment regimen. Our program uses an innovate approach using serial MADRS scores to determine which patients remain under a score of 16, for 4 weeks or longer for the maintenance phase , after 1-3 initial weekly treatments . Patients diagnosed as treatment refractory are offered infusions based on MADRS score of >16. About a third of patients continue to sustain improvement over 4 weeks with MADRS < 16 .Their GAF scores show significant improvement over the period of intermittent treatments compared to baseline. So far 79 infusions have been administered to 28 and 9 patients continue to be on the Ketamine maintenance program. Three quarters of all the patients require a treatment interval of 4 weeks and more going up to 35 weeks. There is a bimodal distribution of 4 and 7 weeks between infusion intervals, with a median of 5.5 weeks. Our innovative approach provides a solution determining which patients are best suited for maintenance on Ketamine infusions to improve their level of functioning & quality of life.

No. 13
Comparison of Depression Frequency Among Outpatients and Their Healthy Attendants at Civil Hospital Karachi, Pakistan
Poster Presenter: Faisal Kagadkar, M.B.B.S.
Lead Author: Hudaisa Hafeez, M.D.

SUMMARY:
Objective: To determine the frequency of depression in patients and their healthy attendants at medical OPD of Civil Hospital Karachi. Patients &Methods: Patients attending medical OPD were administered DSM-IV questionnaire comparative observational. An equal number of healthy attendants with the patients were selected as control. Diagnosis of depression was made if DSM-IV score of = 5 was present. Frequencies of depression were compared with control. Two groups were analyzed on the basis of gender, marital status, education, and occupation. Results: During the study, 236 patients and an equal number of controls were included. The mean DSM-IV score was significantly higher in the patient group (3.8/Standard Deviation?) as compared with control group (1.6/ Standard Deviation?). The number of depressed subjects in control group was 19 (8.1%) and that in the patient group was 99 (41.9%), the difference was statistically significant (x2 test; p-value <0.001). No difference in frequency of depression was found on basis of marital status but significant differences were found on the basis of gender, education, and occupation. Conclusion: Significant numbers of patients attending the medical OPD were depressed.

No. 14
Suicidality in Depressed Patients With ADHD: A Nationwide Longitudinal Study
Poster Presenter: Saad Salman, Pharm.D.
Co-Authors: Sajid Asghar, Fahad Hassan Shah, Jawaria Idrees, Zunaira Nauman, Ayesha Dar, Muhammad Usman, Turfa Nadeem, Hafsa Bibi

SUMMARY:
Background Suicide in depressed patients' is one of the major health concern and gained substantial attention in public health fields. However, the role of attention-deficit/hyperactivity disorder (ADHD) in suicide attempts among patients with co-morbid different types of depressions remain unknown. Methods We identified 1397 depressed adolescents and adults: post-partum depression (n=145), pre-menstrual dysphoric-disorder (n=196), bipolar disorder (n=535) and major depression (n=521) with co-morbid ADHD from 2001 to 2010 in Pakistan and Afghanistan from 116 major hospital's record and matched according to gender (587 males, 810 females) and age (11-17) with 6335 (control) patients with types of depression alone; a

longitudinal cohort observed until the end of 2015. Patients with other psychiatric comorbidities were excluded from the study. Findings Patients with major depression and ADHD had a greater incidence of completed suicide than those with any depression type alone (2.9% vs. 0.9%, p = 0.006). After adjustment for psychiatric comorbidities, a cox-regression analysis demonstrated that the independent risk-factor for attempted suicide, later in life was ADHD, among depressed patients (HR: 3.12, 95% CI: 1.44-4.27). Interpretation Adolescents with comorbid major depression and ADHD had an elevated risk of attempted suicide as compared to patients with any other type of depression alone. This is the first study, of its kind, to demonstrate an independent influence of ADHD on attempted suicide among different types of depressed young adults and adolescents. We have not assessed risk of suicide due to other psychiatric co-morbidities.

No. 15
WITHDRAWN

No. 16
WITHDRAWN

No. 17
Smoking and Mental Illness: Stop Hitting the Snooze Button
Poster Presenter: Edwin Kim, M.D.
Co-Authors: Anil A. Thomas, M.D., Jose Vito, M.D.

SUMMARY:
If the first step in enhancing access to effective care is eliminating barriers to treatment, then psychiatrists can no longer subscribe to outdated beliefs. This presentation will identify obstacles, which limit potential success of smoking cessation in mental health, and outline scientific evidence and effective psychotherapy skills that can be applied while treating individuals motivated to quit and those not yet ready to quit. First, motivated individuals, despite their desire to quit smoking, often do not receive interventions shown to reduce nicotine cravings. There is a myth that pharmacological options don't work or make mental illness worse. The audience will understand the most recent evidence-based pharmacological interventions for smoking cessation. Cochrane reviews of pharmacological interventions will be summarized with focus on varenicline in combination with nicotine replacement therapies. Second, unmotivated individuals not yet contemplating quitting often do not receive a key brief psychotherapy that can elicit a change in their motivation. There is a myth that patients with mental illness and substance use disorders do not want to quit or that cannot be motivated to quit. The audience will understand the most recent evidence-based psychosocial interventions for smoking cessation with focus on motivational interviewing techniques.

No. 18
Addressing Implementation Challenges in Assessing Mental Health Disorders in Primary Care
Poster Presenter: William Emmet
Co-Authors: Carol Alter, Karen Sanders, Angela Kimball

SUMMARY:
The integration of behavioral health with primary care starts with the primary care clinician's willingness to assess and treat their patients' mental health disorder, yet primary care practitioners are overworked and underpaid, and asking them to add an additional assessment is often a non-starter. Issues around clinician mindset, workflow, patient engagement and clinical decision-making need to be overcome to address mental health needs of primary care patients that exacerbate medical comorbidities and their accompanying costs. Use of electronic based multicondition assessments that deliver results directly to the electronic medical record can streamline workflow and facilitate clinical decision making. It improves access to care, enables measurement of results, and encourages patient engagement. This poster will demonstrate ways to address the barriers in primary care that limit uptake of screening for behavioral health disorders and show how they can be overcome through electronic data collection, measurement, and effective utilization.

No. 19
“Hey, Doc! I Need Double Portions”: The Planning and Implementation of a Nutrition Program in a Community Crisis Residential Unit

Poster Presenter: Chanda Mayers-Elder
Co-Authors: Nathalie Butler, Jenna Lin

SUMMARY:
Supporting healthy lifestyle changes is one of the more challenging tasks in treating persons with serious mental illnesses. Doing this in a community mental health setting with limited funding is even more challenging. Research shows that persons with serious mental illness tend to have a decreased lifespan on average of 25 years earlier the general population due to treatable medical conditions such as cardiovascular, pulmonary and infectious diseases. While mental health professionals oftentimes encourage healthy lifestyles, considering the metabolic effects of certain psychotropic medications, a significant number of persons served may not fully understand this concept. Furthermore, those who are indigent, under-/uninsured or seemingly marginalized often cannot fathom how this can be attainable especially when food sources may be limited to shelter, soup kitchen or food bank provisions. Crisis residential units (CRUs) were established as an alternative to hospitalization for voluntary admissions. They are also utilized as a "step-down" option for those who no longer meet criteria for inpatient hospitalization and are in need for further stabilizing on medications in a structured and therapeutic environment. CRUs aim to support recovery through various group programming, case management, individual therapy and medication management in an attempt to help persons served develop better coping mechanisms in preventing or alleviating symptoms that may lead to further decompensation in functioning. CRUs in community mental health networks tend to have limited budgets and have similar challenges with supporting healthy food options as shelters, soup kitchens, and food banks falling short on reinforcing that component of overall wellness. This workshop will address the challenges in planning and executing a nutritionally-balanced menu in a community CRU. Through audience participation, participants will learn creative ways to educate patients on how to incorporate healthier food options into their diets and empower them to adopt other positive lifestyle changes despite severe budgetary and housing limitations.

No. 20
Withdrawal of Stimulant Medication in an Adult With Intellectual Disability, Autism, Childhood ADHD, and Challenging Behavior
Poster Presenter: Richard Hillier
Co-Author: Rupal Patel, M.B.B.S.

SUMMARY:
Ms. H.F., a 22 year old woman of mixed ethnicity with a moderate intellectual disability, autism, challenging behaviour and a childhood diagnosis of ADHD. The patient was living in a purpose built one bedroom flat and supported by one carer at all times. She presented to psychiatry due to longstanding issues around challenging behaviour, repetitive behaviours and poor sleep. Challenging behaviour was in the form of physical aggression towards carers and property destruction, often occurring when demands were placed on H.F. From functional behaviour analysis, it was shown that there were several serious episodes of challenging behaviour with no apparent trigger. The patient was taking Concerta 36mg am and 18mg pm which had been initiated in childhood for the treatment of ADHD symptoms. Following discussion with the family and carers, we agreed to gradually reduce and stop Concerta. Follow up at 6 weeks was positive with reported improvements in levels of agitation and anxiety. Incidents of challenging behaviour had reduced and the patient was engaging in more activities both inside and outside of the home. In addition, carers reported improvements in sleep from 4-5 hours to 7-8 hours post cessation of Concerta. In this poster, we discuss the increasing trend to use stimulant medication in adults with ADHD. In this case example, we report an improvement in presentation and behaviour in a patient with intellectual disability and autism following withdrawal of Concerta XL, possibly due to a reduction in anxiety levels.

No. 21
Switching Our Pitch and Drumming to a Different Beat: Strengths-Based Interventions for Exceptional Minds
Poster Presenter: Lamis Jabri, M.D.

SUMMARY:

When learning about Autism Spectrum Disorder (ASD) and other neurodevelopmental disorders, we are trained to identify deficits, provide timely referral for multidisciplinary assessment, and proactively seek evidence-based interventions. Despite the irrefutable helpfulness of the therapeutic strategies designed to address specific deficits in speech/communication, behavioral/emotional regulation, self-help and social skills, we argue that there remains a problem with our "deficit-based" approach. Indeed, during and beyond the school years, there remains a great need for strengths-based educational and employment opportunities for individuals with neurodevelopmental disorders. Despite the significant challenges they face, many children and young adults who exhibit symptoms of ASD (or other neurodevelopmental disorders) also exhibit exceptional skills and talents: reading/writing early, visual and auditory memory, musical and other artistic talent, mathematical abilities etc. These range from remarkable to prodigious. Often, care-takers and professionals alike are unsure how to conceptualize these abilities. At worst, these are considered "splinter skills", and are discouraged, for fear of hindering the progress of development. At best, amazement is expressed, but the potential is left unexplored. As a mother and a clinician, I felt disheartened when faced with these specific concerns with my own son, then diagnosed with ASD at age two. A frantic online search led me to the work of Dr. Darold Treffert on Savant syndrome, Hyperlexia and giftedness. I reached out to him, as hundreds of families had over the years. Upon his recommendation, I consulted and met with respected professionals who designed innovative strengths-based interventions in their respective disciplines to address the needs of individuals with neurodevelopmental disorders: Susan Rancer (Music therapist), Jim and Julia Billington (Hidden Wings school), Phyllis Kupperman (Speech and Language therapist). Hoping this information would be useful to all of us at the front lines, these renowned professionals all graciously agreed to allow me to describe their ongoing work herein. First, we present new insights into diagnostic and prognostic differences between ASD, Savant Syndrome and Hyperlexia through careful analysis of over 200 clinical cases from Dr. Treffert's database, leading to important suggestions for clinical/educational strategies. Second, we describe existing innovative strengths-based interventions for speech/language development, self-help and social skills, and emotional regulation. These are drawn from the literature as well as the named experts' clinical experience through the programs they have designed. Finally, we describe specific success stories illustrating how to expose, foster and promote talents and strengths to help individuals with neurodevelopmental concerns attain higher education and gainful employment.

No. 22

Current State of Training in Autism Spectrum Disorder and Developmental Disabilities Across New York State Psychiatry Training Programs

Poster Presenter: Lan Chi Krysti L. Vo, M.D.

SUMMARY:

Background: Psychiatric management of children with autism spectrum disorder and intellectual disability (ASD/DD) can be complex. A recent study found that almost half of directors of child and adolescent psychiatry (CAP) fellowships endorsed the need for additional resources for training on ASD/DD (Marrus et al 2014). The goal of this system of care project is to evaluate the current status of training in ASD/DD and to identify the specific types of resources that may helpful to psychiatry training directors in the state of New York. Methods: General psychiatry and CAP training directors from Accreditation Council for Graduate Medical Education (ACGME) institutions in New York State were surveyed. This included 31 general psychiatry program directors and 16 CAP program directors. Directors were emailed a link to the survey in Sept-Oct 2016. The initial email was followed by two reminders email, allowing a total of 3 weeks to respond. Respondents were not anonymous as they were instructed to write the name of their program as question #1 of the survey. Participation was voluntary and there was no reimbursement. The survey consisted of 7 multiple-choice, 2 multi-select and 2 free response questions for a total of 11 questions. The survey was programmed using SurveyMonkey. Questions focused on the following: (1) educational exposure to ASD/DD through didactics and clinical cases; (2) available clinical

settings for clinical exposure; (3) interest in additional resources and (4) preference for type of additional resources.Data were analyzed in Microsoft Excel (2016). Graphs were created using Microsoft Excel. Results: The response rate was 63.8%. Fifty percents of programs have residents with 7 or more clinical cases with ASD/DD in a year and 83.3% of programs gives six or less didactic lectures regarding management of ASD/DD. Most programs (86.7%) would like more resources to strengthen training in ASD/DD. When asked which top three resources would be most useful to trainees, the choice with the most preferences was online videos available anytime with 56.7% of preferences, follow by live in person lectures and reading package, both at 50% of the preferences. Conclusion: Our results suggest that many training program directors would like more resources to train residents and fellows about ASD/DD. Training program directors' top preference for training curricula was online video lectures. They are also interested in a wide variety of other resources. These findings will be discussed with the American Academy of Child and Adolescent Psychiatry Autism and Intellectual Disabilities Committee and the American Association of Directors of Psychiatric Residency Training. It would be critical to develop a curriculum on ASD/DD that contains a wide variety of resources for training programs.

No. 23

Promoting Mental Health at a Student-Run Free Clinic With Community Outreach and Quality Assurance

Poster Presenter: Manjiri Nadkarni, M.S.
Co-Author: Shivani Patel

SUMMARY:

Background: Medically underserved and vulnerable patient populations face challenges that can impact mental health. We provided two interventions to improve mental health in the Newark community through the Student Family Health Care Center (SFHCC). (1) We provided a patient education program at a homeless shelter outreach site: Apostle's House. (2) We worked on improving depression screening at SFHCC through a quality assurance project. Methods: Apostle's House Education Program: Apostle's House women, administration, and student clinic leaders identified a need for health education and support for healthy relationships, body, and mind. A discussion series, "Girl Talk", was implemented during August 2016 to July 2017. Format of these monthly 2-hour sessions included open discussion, didactic time, reflective activities, and workshops. The topics focused on personal challenges faced by the women in their daily lives such as violence and past trauma, barriers and potential solutions to healthier eating on a budget, incorporating exercise for mental health, birth control, and parent-child relationships. Verbal feedback was solicited from participants. Depression screening at the SFHCC: During August 2016 to May 2017, the SFHCC directors were trained and patients (>=18 years) were screened using the Patient Health Questionnaire (PHQ-2). PHQ-9 was provided if PHQ-2 score was >3. Quality assurance chart reviews were performed to assess depression screening rates. Results: Seven sessions of "Girl Talk" were conducted with 46 Apostle's House women and 36 student facilitators. Over the course of the year, 48 out of 71 patients that visited SHFCC received PHQ-2 (68%) and 13 out of 14 patients who screened positive on PHQ-2 received PHQ-9 (92.8%). With the reinstitution of the depression screening training, the screening rate of PHQ-2 increased from 49% to 68% during this period. Results indicated that 47% had moderate to severe depressive symptoms. Conclusion: (1) The "Girl Talk" program was very well received and is continuing for a second iteration as well as being incorporated into regular clinic activities. The women were more aware of the resources available to them. Students fostered greater trust and relationships with the participants. We also collaborated with another student organization to provide voluntary childcare services during these sessions so more women could participate. A hybrid support and didactic group run by medical students can be a fruitful expansion of student-run free clinics to address mental health and wellness concerns identified through community needs assessment, benefiting both community and medical student members. (2) Continued training and reminders for students are important to maintain improvement in depression screening rates. Quality assurance for depression screening programs should be conducted by student-run free clinics and can inform future screening programs.

No. 24

Improving Psychiatry Resident Knowledge in Eating Disorders Using Live and Simulated Patients: Early Experience With Curriculum Development

Poster Presenter: Ashley G. Ellison, M.D.

SUMMARY:

Background: Since the 1950s, the incidence of eating disorders (ED) has been steadily increasing. Anorexia nervosa continues to have the highest mortality rate of any mental illness. Despite this, psychiatry residents receive on average less than five hours total of ED lectures during their four-year residency. Twenty-four percent view their ED instruction as inadequate. Additionally, no formalized curriculum exists to teach residents about ED. As a result, psychiatrists post-residency often decline to care for patients with ED due to their lack of knowledge. Herein we present the initial evaluation data from an ongoing ED curriculum being recently instituted at Tulane University psychiatry residency program and its impact on resident knowledge. Methods: Literature review was performed to evaluate the components needed for a curriculum on ED. A 5.5 hour curriculum was created which included a 2-hour evidence-based lecture on anorexia, bulimia, binge eating disorder, and other ED. The curriculum involved a presentation and question/answer session with a live patient in recovery from an eating disorder. There was a simulated patient session in which residents interviewed and managed a simulated patient with an ED. Pre-curriculum, residents completed a 20-item assessment test measuring their fund of knowledge in ED; they also rated their confidence (defined as their self-perceived comfort in managing ED) and competence (defined as their self-perceived evidence-based clinical knowledge) on a 1 to 10 scale. Post-curriculum, residents completed repeated the 20-item assessment and rated their confidence and competence. Results: 26 psychiatry residents have completed the curriculum thus far. Average post-curriculum assessment score was 72% compared to pre-curriculum score of 52%. Residents felt more comfort in treating ED post-curriculum with post-curriculum confidence increasing to 7.41 (on a scale of 1 to 10) compared to 4.41 pre-curriculum. Residents also had improved self-perceived clinical knowledge; post-curriculum competence increased to 7.41 from 4.28 pre-curriculum. Pre-curriculum, 27.6% of residents noted they would refer ED patients elsewhere due to their perceived lack of knowledge on ED. As a stark difference, 0% of residents post-curriculum would refer patients elsewhere. Conclusion: Preliminary results of this study demonstrate that residents have a lack of evidence-based knowledge, low self-perceived confidence, and low self-perceived competence in ED. The initial 26 participants demonstrate that after a curriculum is taught, residents greatly improve their fund of knowledge, confidence, and competence in addition to having a greater willingness to accept patients with ED. More curriculum series are being taught to additional residents to allow sufficient power for statistical analysis.

No. 25

My Brain Won't Let Me Sleep: TBI and Insomnia

Poster Presenter: Adekola Alao, M.D.

SUMMARY:

Traumatic brain injury (TBI) affects nearly 1.5 million individuals in the United States each year. During peacetime, over 7,000 Americans with a diagnosis of TBI are admitted to military and veterans hospitals every year; this number increases significantly during combat, during which TBI may comprise up to 20% of survivor casualties. Pain and discomfort relating to injuries are frequent causes of insomnia or sleep disturbance in TBI patients. Sleep disturbance can manifest as difficulty falling or staying asleep, early morning wakening and non-restorative sleep, and affects up to 30% of individuals with TBI. Because there are few studies on pharmacotherapy for sleep disturbances in TBI, many physicians base their intervention on experience with the general population. A literature review was performed and recommendations for treatment of sleep disturbances in patients with TBI are summarized here based on published findings. Conclusion Non-pharmacological means should be the first-line treatment for sleep disturbances in patients with TBI. These include sleep hygiene and cognitive behavioural therapy. Physicians and other clinicians should lend careful attention to the specific sleep complaint, adverse effect profile of the medication,

as well as the anticipated duration of treatment before deciding upon a sleep agent for patients with TBI. References 1. [CDC] Centers for Disease Control and Prevention. 2008 Jan 22. Traumatic Brain Injury. http://www.cdc.gov/ncipc/tbi/TBI.htm Accessed 3 April 2008. 2. Ouellet MC, Beaulieu-Bonneau S, Morin CM. Insomnia in patients with traumatic brain injury: frequency, characteristics, and risk factors. J Head Trauma Rehabil 2006; 21(3):199-212. 3. Wu R, Bao J, Zhang C, Deng J, Long C. Comparison of sleep condition and sleep-related psychological activity after cognitive-behaviour and pharmacological therapy for chronic insomnia. Psychother Psychosom 2006; 75(4):220-8.

No. 26

Left Prefrontal Cortex High-Frequency Deep TMS Alleviates Central Hypersomnolence: Case Report

Poster Presenter: Manish Sheth, M.D., Ph.D.

SUMMARY:

Title: Left Prefrontal Cortex High Frequency Deep TMS Alleviates Central Hypersomnolence: Case Report Authors: Manish Sheth, M.D., Ph.D., Shashita Inamdar, M.D., Ph.D., Newshaw Karkhanehchin, B.S., Katie Nguyen B.S., Brandyn Roach, B.A., Mayra Ramirez, B.A. Background: Patients with myotonic dystrophy frequently exhibit excessive daytime sleepiness. Narcoleptic patients, exhibit excessive daytime sleepiness, shortened sleep latency, shortened REM latency, fragmented sleep and sleep attacks. Central hypersomnia is a significant cause of disability in both of these disorders. The circadian rhythm and recovery time necessary after sleep deprivation are unchanged in these patients but their wake promoting signals are affected. We treated a 41 year-old-man with treatment resistant major depressive disorder, narcolepsy and myotonic dystrophy type I with deep TMS to the left prefrontal cortex (L-PFC). Previously failed medications for depression included: Wellbutrin, Lexapro, Cymbalta and Abilify. Previously failed medications for hypersomnia included: Nuvigil Methods: Thirty daily sessions of dTMS were administered over the L-PFC using the Brainsway H-1 Coil at 18HZ, 120% of resting hand MT, totaling 1980 pulses per day. Progress was assessed with the PHQ-9, BDI-II and GAD-7. Results: The patient's depression and excessive daytime sleepiness remitted with the deep TMS. PHQ-9 decreased by 91.3%, GAD-7 decreased by 95% and BDI-II decreased by 81.1%. In regards to hypersomnia, PHQ-9 Q3 & Q4 decreased from a 6 to a 1. This was consistent with his reported resolution of his excessive daytime sleepiness, lack of energy and overwhelming exhaustion. Conclusion: Left prefrontal cortex high frequency deep repetitive transcranial magnetic stimulation may be beneficial in the treatment of central hypersomnolensce. Discussion: A confounding factor in this case is the fact that the patient had a depression, which can also manifest with sleepiness and fatigue. It is unlikely that all the improvement in sleepiness was due to remission of the depression. A potential mechanism for improvement after high frequency deep TMS, is that long term daily high frequency TMS increases cortical excitability in a long-term-potentiation like fashion. This increase in neuronal firing in the meso-cortico-limbic projections and other projection may compensate for the deficiencies caused by the loss of hypocretinergic neurons.

No. 27

Integrating a Nutritional Intervention Education for Patients With Serious Mental Illness Into the Psychiatry Clerkship

Poster Presenter: Shinnyi Chou

SUMMARY:

Need: Recent increase in Primary and Behavioral Health Care Integration Model (PBHCI) utilization to combat care disparities in patients with serious mental illness (SMI) has led to higher accessibility and reduced ER visits.1,2 However, PBHCI is not routinely incorporated into medical education, and there is no consensus as to an effective strategy. Purpose: Contact-based education may reduce negative physician attitudes toward patients with SMI.3 We present here a clerkship PBHCI experience that aims to reduce stigma, raise awareness of the interplay between psychiatric and preventive care, and cultivate the sensibility that optimal outcomes for individuals with SMI require an integrated approach. Methods: Psychiatry clerkship students assigned to Community Alliance Mental Health Agency were paired with patients for a three-part nutritional intervention program. Students facilitated discussions regarding biopsychosocial

barriers toward a heathy lifestyle and basic nutrition knowledge. They then led shopping and cooking workshops with patients, teaching strategies for cost-effective, health-conscious purchases and food preparation methods. Activities were supervised by the Agency's wellness coordinator and students processed the experience with the coordinator post intervention. Outcomes: Overall students believed the experience to be worthwhile. Initially, students were "nervous about working with individuals with serious mental illness." After the intervention, they became "more comfortable… working with patients with a history [of mental illness]" and "rather than only focusing on their mental health, learn to look at the whole individual to promote their overall health." Feedbacks were reviewed incorporated accordingly, including providing "education in nutrition" for students and a "fundamental piece of literature that explains food nutrients" for patients. Conclusion and feasibility: Students appreciated the PBHCI experience and handled the sometimes unpredictable nature of working with patients with SMI well. There is improved perception of working with this population and increased appreciation for psychiatry. Clients also consistently responded positively to Agency personnel. We anticipate minor modifications going forward, as the program becomes an established component of clerkship experience at this community site.

No. 28

A Program Partnering Medical Students With ACT Teams to Improve Chronic Medical Conditions in Patients With Severe Persistent Mental Illness

Poster Presenter: Heather Burrell Ward, M.D.

SUMMARY:

INTRODUCTION: There is great need for better primary care follow up in the mentally ill population. Their chronic mental illness, coupled with lack of health literacy, marginalized socioeconomic status, and comorbid medical conditions, prove to be prohibitive barriers to care. To address this need, we created a novel program that partnered medical students with Carolina Outreach's Assertive Community Treatment (ACT) team. Our purpose was threefold: 1) empower patients to affect change in their health behaviors and improve their health outcomes, 2) decrease stigma of mental illness among medical students through service learning in longitudinal outpatient psychiatric care, and 3) build leadership skills with peer-teaching in the context of a multidisciplinary healthcare team. METHODS: Carolina Outreach identified patients with comorbid psychiatric and medical conditions who necessitate additional coordination of their medical care. A team of 2 medical students (1 first year, 1 third year or above) served as health care liaisons for each patient. Through monthly visits with ACT team staff, student teams worked with each patient to identify health goals and facilitate progress toward those goals. Senior students taught and led the first year students in motivational interviewing toward achieving these health goals. Students also encouraged conversations about medical conditions and medication compliance and facilitated regular primary care appointments for each patient. Students also attended weekly didactic sessions on the diagnosis, treatment, and medical comorbidities of severe mental illness as well as goal setting, motivational interviewing, and health behaviors coaching. RESULTS: In order to measure the effectiveness of our program, we conducted baseline and end-point surveys of both the patients and medical students. We assessed patient attitudes about behavior change through the Patient Activation Measure and used the Short-Form 12 Health Survey to assess if these motivations actually led to changes in patients' quality of life. We tracked medication adherence, appointment attendance, and progress towards their self-identified health goal. We assessed medical student attitudes towards patients with mental illness and toward the field of psychiatry through the Belief Towards Mental Illness Scale and the Balon Attitudes Towards Psychiatry Scale, respectively. CONCLUSION: Medical students may be able to improve chronic medical conditions in patients with severe mental illness by coordinating care between ACT teams and primary care providers and by facilitating discussion about patients' health and behaviors. Service learning is an effective way to decrease the stigma associated with mental illness.

No. 29

FIT Clinic Peer Support Group: Easing the Mental Burden of Re-Entry in the Incarceration Capital of

the World
Poster Presenter: Zachary Lenane

SUMMARY:
The U. S. imprisons more people than any other country in the world. Within the U.S., Louisiana has the highest incarceration rate, with twice the average state per capita rate. Formerly incarcerated persons are sicker and have significantly higher rates of mental illness than the general population. They are more likely to have experienced trauma as children and adults, and incarceration itself is a traumatic stress capable of causing post-traumatic stress reactions following release. These individuals also face numerous social barriers to medical and mental health care due to their formerly incarcerated status. Regular counseling in particular has been largely unavailable to this population due to a lack of available, affordable services for uninsured and Medicaid patients in the New Orleans area. The Formerly Incarcerated Transitions (FIT) Clinic was started in 2015 by Tulane School of Medicine faculty and students to provide free transitional healthcare and case management services for individuals recently released from prison in Louisiana. Funding from the 2016-2017 Helping Hands Grant has allowed the FIT Clinic to begin addressing the mental health needs of this population. The sessions focus on the practical aspects of re-entry and the emotional impact of incarceration. They are led by formerly incarcerated individuals and mental health specialists associated with Positive Living Treatment Center (PLTC), a community mental health services organization. Participants are recruited through the FIT Clinic, its community partners, and outreach by formerly incarcerated participants. Those who are interested and have completed the re-entry process are recruited as discussion leaders. Fourteen sessions have been held since September, 2016 with a median attendance of 15 participants. The program is currently being evaluated. Year one (current) participants will complete anonymous, post-intervention surveys assessing satisfaction with the program (CSQ-8), perceived social support (SSQ6), PTSD symptoms (PCL-5), and depression symptoms (PHQ-9) in September, at the end of the grant period. Year two participants will complete pre-intervention surveys in October and post-intervention surveys every six months over the next year.

No. 30
Empowering Underserved Youth: An Adolescent Mental Health Initiative Serving Urban Middle Schoolers
Poster Presenter: Nancy Shenoi, B.S.
Co-Author: Juliann Tea, B.S.

SUMMARY:
Mental health disorders account for a considerable disease burden in Houston, Texas, where more than 152,000 children are living with a psychiatric diagnosis in the metropolitan area's largest county, Harris County. Early interventions can foster resilience, reinforce healthy behaviors, and introduce coping mechanisms and stress-management techniques. A mental health curriculum developed by Baylor College of Medicine medical students, psychiatry and pediatrics residents, child and adolescent psychiatry fellows, and school faculty, was introduced to students at Yolanda Black Navarro Middle School, a low-income public middle school in Houston, Texas where 97% of students are economically disadvantaged. Mental health and general health classes were taught by medical students biannually with support from Citizen Schools, a national non-profit organization dedicated to closing the opportunity gap by providing various after-school learning options to at-risk students. The two ten-week module courses, "Me, Myself, and I", which addressed mental health awareness, and "Medical Madness, " which focused on the human body, gave students a chance to discuss social stressors and empowered them to improve their health and well-being. Medical student mentors encouraged students to pursue careers in the health professions and anonymously surveyed them on the program's impact and efficacy. At the program's conclusion, middle school scholars recognized the need to address mental health topics including bullying, relationships and drugs, while learning about emotional regulation and interpersonal communication.

No. 31
Cognitive Screening for Referral to Cognitive Remediation in Outpatient Psychiatric

Rehabilitation: Prevalence of Impaired Cognition Across Diagnoses

Poster Presenter: Raymond Kotwicki, M.D., M.P.H.
Co-Author: Philip D. Harvey, Ph.D.

SUMMARY:
Background: Cognitive remediation therapy (CRT) interventions are increasing in their use in outpatient settings. These interventions have demonstrated their efficacy for improving functional outcomes when combined with appropriate rehabilitation interventions. However, most of these interventions have been targeted at outpatients with schizophrenia. It is not clear how many cases with other conditions would manifest cognitive impairments and whether baseline screening would be an effective triage tool. This study addressed this question. Methods: Consecutive admissions (N=337) to a residential and outpatient young adult rehabilitation program were administered the Brief Assessment of Cognition for Affective Disorders (BAC-A) at the time of admission. Diagnoses were obtained with the MINI International Psychiatric Inventory. A cut-off t-score of 40 (one SD below the normative mean), a MoCA score of ≤ 25, and or designation of the Cognition and Frist Episode (CAFÉ) Track were the criteria used for selection of cases in need of CRT. Results: The sample received diagnoses that were bipolar disorder for 23%, major depression for 48%, and schizophrenia 12%. Other diagnoses were less common. The sample was 52% female. Overall 22% of the cases met criteria on the BAC-A for impairment based on a t-score of 40 or less. The proportion of cases who met criteria was quite similar across diagnoses, although the schizophrenia sample was considerably smaller. Thus, a minority of cases were cognitively impaired. Discussion: In a younger sample of patients seeking psychiatric rehabilitation, the presence of global cognitive impairment was lower than reported in previous studies of similar diagnostic groups (Reichenberg et al., 2009). The sample manifested considerable everyday disability, but this facility does not accept Medicaid/Medicare for payment demographics may be different than in broader samples. Cognitive impairment in these patients at this facility has been previously reported to correlate with everyday disability (Vargas et al., 2014), so the demographic differences suggest the use of different global criteria for cognitive impairment.

Saturday, October 21, 2017

Poster Session 4

No. 1

Stigmatization and Challenges in Diagnosing Adult ADHD

Poster Presenter: Lidia Klepacz, M.D.
Co-Authors: Elizabeth Leung, Annie Xu, M.D.

SUMMARY:
ADHD has long been thought to be a disabling and common disorder that occurs only in childhood, more recent researches suggest that ADHD persists into adulthood in high proportion of cases. It is estimated that up to 4.5% of adults meet diagnostic criteria for ADHD. ADHD is associated with other comorbid psychiatric disorders such as substance use, affective disorder, personality disorders, and also remarkable correlation with poor socio-economic outcome and functional impairment. ADHD is also associated high work impairment with a statistically significant 22.1 annual days of excess lost role performance compared to those without ADHD. Adult services, however, for people with ADHD remain relatively scarce despite strong evidence for the benefits of diagnosing and treating ADHD in adults. There are still many professionals that are unsure of the diagnosis and the appropriate use of ADHD medications in adult mental health. Some continue to express fears about treating a "non-existent disease" or causing drug addiction with stimulant medication. The reasons for this are likely to be based on the historical perception of ADHD as a disorder that is restricted to childhood and the continued presence of stigma and clinical mythology that surrounds the disorder and its treatment; and the traditional separation of adult from child psychiatry. What is clear is that there remains a gulf in the perception of the disorder between those working in child and adolescent mental health services and those working in adult mental health, that cannot be explained on the basis of validated evidence based information. Stigma related to the term ADHD is one component of the problem that nearly always arises in the context of

lack of awareness or understanding of available data. Within the mental health professional stigma is further associated with the restricted regulatory status for most of the medications that treat ADHD in adults. ADHD in adults remains a disorder which is poorly understood and where an emotional burden is attached to the term especially among professionals who have not traditionally been involved in the diagnosis or treatment of ADHD. People suffering from ADHD are often stereotyped as lazy, bad or aggressive, or considered to have a behavioral or special needs problem rather than a mental health disorder that requires treatment. The diagnosis may also be overlooked because ADHD is highly symptomatic disorder and those less familiar with the onset, course, psychopathology and comorbidities associated with the disorder may mistake ADHD for other common mental health conditions. In this poster, we will discuss and review literatures regarding to the stigma and challenges in diagnosing adult ADHD.

No. 2

Aripiprazole-Induced Hyperphagia and Weight Gain: A Case Report

Poster Presenter: Annie Xu, M.D.
Lead Author: Elizabeth Leung
Co-Author: Lidia Klepacz, M.D.

SUMMARY:

Context: Atypical antipsychotic medications are associated with metabolic syndromes, weight gains secondary to hyperphagia, adverse cardiovascular profile, and diabetes mellitus. Aripiprazole, a newer atypical agent, has been noted by several literature, clinical trials and studies that has lower incidence of the above mentioned adverse effects comparing to other atypical antipsychotics. We present a patient who developed hyperphagia after Aripiprazole was introduced as an augmentation agent for depression and a subsequent weight gain of 10 pounds in one month. Case report: A 55 year-old female with history of Major Depressive Disorder, mood symptoms had previously been stable on Citalopram for years presented with worsening depression in context of psychosocial stressors. Aripiprazole was started as augmentation agent for her worsen mood. Patient's mood symptoms were effectively stabilization after such medication adjustment. However, patient has noticed increased appetite since the Aripiprazole was introduced to her regimen despite regular three times weekly exercise not changed from baseline. One month since Aripiprazole started, patient has experienced a ten pounds weight gain. Aripiprazole was discontinued at patient's request due to intolerable hyperphagia and weight gain. Patient's hyperphasia subsided as Aripiprazole was discontinued and her weight returned to her baseline in two months. Conclusions: Hyperphagia and weight gain experienced in this patient is a result of a not commonly reported side effects of Aripiprazole. In this poster, we will discuss and review literatures on hyperphagia and weight gain associated with Aripiprazole, and comparison of metabolic profile with other atypical antipsychotic agents.

No. 3

Economic Utility of Combinatorial Pharmacogenomic Testing in Patients With Bipolar Disorder and Generalized Anxiety Disorder: A Prospective Analysis

Poster Presenter: Lisa C. Brown, Ph.D.
Co-Authors: Raymond A. Lorenz, Pharm.D., B.C.P.P., James Li, M.S., Bryan M. Dechairo, Ph.D.

SUMMARY:

Anxiety disorders such as generalized anxiety disorder (GAD) are the most prevalent psychiatric disorders in adults and are frequently comorbid with major depressive disorder (MDD). Treatment costs for anxiety disorders exceed $42 billion per year. Anxiety disorders are also associated with many physical comorbidities, adding to the cost of treating this illness. Bipolar disorder (BD) often goes undiagnosed or may be misdiagnosed as unipolar depression for years. While BD is not as prevalent as unipolar depression, BD is twice as costly. The cost burden of BD lies in this misdiagnosis as well as cost of treatment, which often involves a high level of polypharmacy. Often, patients suffering from anxiety disorders and BD begin a treatment regimen of trial and error, leading to low compliance, high polypharmacy, adverse events, and lack of response. In order to minimize trial and error prescribing and to guide treatment in a more personalized way, clinicians utilize combinatorial pharmacogenomic testing. Combinatorial pharmacogenomic testing

incorporates pharmacokinetic (PK) and pharmacodynamic (PD) genes into a proprietary algorithm to predict what medications may be more genetically appropriate for a specific patient. Patients taking psychotropic medications whose treatment was guided by GeneSight® psychotropic showed a savings of $1036 in medications costs compared to patients whose treatment was not guided by the test. This current report presents a subanalysis of that data pertaining to medication savings for anxiety disorders and BP compared to MDD. Over the course of 1 year, we prospectively collected pharmacy claims data of over 13,000 patients. We analyzed pharmacy spend for patients with GAD, BD, and MDD whose treatment was guided by pharmacogenomic testing compared to guidance without the testing as well as potential cost-savings when medication treatment decisions were congruent with the report. Patients with GAD saved $6747 ($p<0.004$) per member per year (PMPY), BD patients saved $4952 ($p=0.14$) PMPY, and MDD patients saved $3738 ($p<0.004$) PMPY when medication decisions were congruent with the pharmacogenomic report compared to incongruent decisions. Much of the cost savings was directly related to CNS medications but included a large percentage of non-CNS medications like antineoplastic, cardiovascular, gastroenterology, and diabetes medication classes. Overall, this study found that medication treatment costs for GAD and BD can be significantly reduced when utilizing combinatorial pharmacogenomic testing to guide treatment decisions.

No. 4
WITHDRAWN

No. 5
Steroid-Induced Mania: Case Report and Literature Review
Poster Presenter: Sahil Munjal, M.D.
Co-Authors: Virginia Ramos, Moeed Ahmad

SUMMARY:
Since their discovery in the 1930s, steroids have been widely utilized for the treatment of numerous conditions.In comparison to the other well-known physiological side effects, little has been documented about psychiatric disturbances.This is an alarming problem as the rate of prescriptions continues to rise.In light of the scarcity in these adverse effects evidence-based treatment, we present the case of a 49yo Hispanic female with history of depression treated with oral steroids for severe asthmatic/COPD exacerbation developed manic and psychotic symptoms.This served as the stimulus for our literature search on steroid induced mania treatment options.Even though, psychiatric disturbances can occur at any point during treatment, most occur early in the therapeutic course with mania as the most common.Changes in dopamine, cholinergic, serotonin and glutamate system, as well as in alterations in hippocampal neurons plasticity has been found to play a role.These findings have facilitated the treatment/management of steroid psychosis and enabled the implementation of preventive prophylaxis by manipulating monoamine levels. Still, the most effective treatment is complete discontinuation of the offending agent.For patients that cannot tolerate steroid cessation or lower doses pharmacotherapy may be required. Depending on the monoamines levels affected, the psychotropic medication classes effective in idiopathic psychiatric syndromes, can be extrapolated in the management of steroid-psychiatric symptoms. Many psychotropic medications have been explored with some success.For corticosteroid-induced depression and mania, case reports have supported use of antipsychotics, lithium, valproic acid, and carbamazepine.In a systematic review, steroid-induced manic and psychotic symptoms responded to low-dose typical antipsychotics with cessation of symptoms in 83% of patients, 60% of whom responded in less than 1 week and 80% in less than 2 weeks.Olanzapine has also been reported in an open-label trial and case series to be beneficial for patients with multiple underlying illnesses and steroid-induced mixed and manic episodes.Additionally, a case series showed that sodium valproate rapidly and safely reversed manic-like symptoms within a few days without needing to stop corticosteroids, allowing medical treatment to continue.Given what we learned from the literature search, we started our patient on risperidone.Due to minimal improvement, it was discontinued and instead given aripiprazole and Depakote.Unfortunately, patient's symptoms

persisted and her medication was changed to haloperidol and valproic acid.Within a few days, patient began to show improvement and after a 33 day hospitalization, she was discharged.Steroids have shown to be a powerful tool with significant adverse effects.Thus, it's essential to educate patient and caregiver on potential warning signs of psychiatric effects for the prevention of unwanted symptoms.

No. 6
WITHDRAWN

No. 7
Effect of Clozapine on Red Blood Cells
Poster Presenter: Chandresh Shah, M.D.

SUMMARY:
Clozapine is a highly effective antipsychotic drug and is the only one which has received FDA-approval for treatment of treatment-refractory schizophrenia. Unfortunately, it is associated with rare but fatal side-effect of agranulocytosis. In view of this many health regulatory authorities all over the world have implemented clozapine monitoring systems. In 2015, Food and Drug Administration (USA) rolled out Clozapine Risk Evaluation and Mitigation Strategies (REMS). This would help the providers with early warning signs, would alert pharmacy with missed opportunity of intervention and ultimately provide adequate and timely safeguard to patients. The focus of Clozapine REMS has been ongoing monitoring of blood's myeloid lineage, namely of White Blood Cell as well as Neutrophil. To study effect of clozapine on erythroid lineage of hematopoiesis, records of all 10 patients receiving clozapine were reviewed for their laboratory tests before starting treatment and then at intervals of 3 months, 6 months and 12 months. There were 9 male patients (age=49.11 ±16.18 years) and 1 female (age=59.23 years). There were 40% White, 30% Black, 10% Hispanic and 20% Asian patients. They all were diagnosed with Schizophrenia. At the end of 12 months of treatment with clozapine, 60% of patients showed downward trend in total Red Blood Cell (RBC) count (0.53 ±0.45M/uL) while the rest of 40% showed an upward trend in total RBC count (0.05 ±0.03M/uL). The decrease in total RBC count was significantly greater (P<0.05), even though these changes were not clinically significant. Similarly; 80% of patient showed a decrease in hemoglobin (0.43±0.38 g/dL), while the rest of 20% showed an increase of 0.3 ±0.0 g/dL. The changes in value of hemoglobin were not significantly different (P=NS). . But the number of patients affected by drop in hemoglobin were greatly higher (P<0.05). This data show that clozapine might also affect erythropoiesis. Further studies with larger patient population and longer treatment duration are needed to address this issue.

No. 8
Use of Fluvoxamine Augmentation for Relief of Clozapine-Induced Constipation
Poster Presenter: Sina Shah-Hosseini, M.D., M.S.E.
Co-Authors: Pronoy Roy, Raj Addepalli

SUMMARY:
This is a case of a 38 year old Bangladeshi woman with past psychiatric history of schizoaffective disorder on clozapine who presented to our hospital complaining of severe constipation, depression, and command auditory hallucinations to kill self. The patient was admitted to the inpatient psychiatric unit and continued on clozapine treatment. While perceptual symptoms resolved shortly after administration of clozapine 550 mg/day, symptoms of depression and constipation persisted. Despite administration of multiple stool softeners and bowel regulating agents, there was little improvement of constipation, causing the patient significant distress. Medical and Gastroenterology consult team recommendations for relieving constipation included discontinuation of clozapine due to the antimuscarinic side effects. The patient was reluctant to discontinue clozapine, as trial of other antipsychotics had failed in the past, and clozapine was the only agent that effectively treated her psychiatric symptoms. Augmentation of clozapine with asenapine 10 mg/day helped in resolution of psychiatric symptoms. Subsequently the dose of Clozapine was reduced to 250 mg/day, and fluvoxamine 100 mg/day was added to the regimen. This allowed the substantial reduction of clozapine dosage and maintenance of therapeutic clozapine levels and subsequent improvement of debilitating constipation. We discuss our strategy to ameliorate the antimuscarinic effects of clozapine and

improving compliance by decreasing dosage of clozapine. This was primarily achieved by making use of the drug interaction of fluvoxamine with clozapine in a beneficial way. Fluvoxamine inhibits cytochrome P450(CYP)1A2 for which clozapine is a substrate, and results in maintenance of therapeutic levels of norclozapine and total clozapine levels at lower doses of clozapine. The outcome in our case was relief of severe constipation along with amelioration of psychotic symptoms.

No. 9

Development of Diabetic Ketoacidosis in a Patient on Loxapine, a Clozapine Analog

Poster Presenter: Kerry A. Sheehan
Co-Authors: Amanpreet K. Mashiana, Douglas J. Opler

SUMMARY:

Ms. M., a 61-year-old woman with a past psychiatric history of schizophrenia and cocaine use disorder, presented to the psychiatric consultation service with a one-month history of weakness and falls. She was admitted to the inpatient medicine service for treatment of abscesses, acute kidney injury, and diabetic ketoacidosis (DKA). The patient had been diagnosed as borderline diabetic six years prior, but did not have any follow up testing or treatment for diabetes in the interim. Around the time that the symptoms that prompted the current admission first started, she was switched from haldoperidol to loxapine in order to minimize adverse effects. Loxapine is considered a typical antipsychotic, but has a structure similar to clozapine. Although generally considered one of the most effective antipsychotics in terms of treatment efficacy, clozapine is notorious for promoting metabolic syndrome. While the abscesses themselves could have contributed to the development of DKA, there is the possibility that loxapine might have also contributed to the metabolic abnormalities. Our case joins one prior case report of DKA developing in a patient on loxapine. DKA is usually seen in much younger patients, making the case for glucose intolerance secondary to loxapine more plausible in this patient when considering her age. On the other hand, while clozapine is generally associated with weight gain, recent studies on the use of loxapine in autism spectrum disorder have also identified a reduction in weight and BMI in these patients compared to other antipsychotics. Likewise, the patient in this study also had a 20-pound weight loss. Other data suggests that loxapine may contribute as much to extrapyramidal symptoms as typical agents. In this poster, we discuss the possibility of this adverse side effect of the rarely utilized loxapine and the ambiguous nature of the medication's characteristics, some of which appear to be comparable to atypical antipsychotics and others of which are more similar to typical agents. At the same time, we highlight the potential benefits to be gained from further characterization of the properties of this low cost agent, which may have better efficacy on negative symptoms than many other available antipsychotic agents and is also available in a novel formulation as the only inhaled antipsychotic medication.

No. 10

Diagnostic Dilemmas: Managing Psychosis, Delirium, and Catatonia in a Medically Ill Patient

Poster Presenter: Elia E. Acevedo-Diaz, M.D.
Co-Authors: Rachel Meyen, Sparsha Reddy, M.D.

SUMMARY:

Case description: A 71-year-old medically ill African American male with schizoaffective disorder, bipolar type, and post-traumatic stress disorder was admitted to the medical service for management of stage IV sacral decubitus ulcer and acute kidney injury secondary to recurrent urinary tract infection. His prolonged hospital course was complicated by ongoing delirium and psychosis, punctuated by episodes of catatonia. Discussion: When catatonia, psychosis, and delirium overlap in an individual patient, prioritizing which symptoms to target can present a diagnostic challenge. Care must be taken to address the most imminently harmful symptoms while avoiding exacerbation of the comorbid conditions. Catatonia, delirium, and psychosis each require different therapeutic approaches, with the treatment of one syndrome potentially worsening another. This case report explores some of the overlapping clinical features of psychosis, delirium, and catatonia and provides strategies to manage these comorbid syndromes in a medically ill patient.

No. 11

Qualitative Report of Young Adult Cancer Survivors' Participation in a Mindful Self-Compassion Video Chat Intervention

Poster Presenter: Winfield Tan

SUMMARY:

Background: Young adult (YA) cancer survivors report substantial distress, social isolation, and body image concerns that can result in poor quality of life years after treatment completion. Developing self-compassion may be beneficial for supporting YA survivors' management of psychosocial challenges (i.e. distress, hardships, and perceived personal inadequacies) that arise after treatment completion and impede successful reintegration into life activities and goals. However, a self-compassion intervention, such as Mindful Self-Compassion (MSC), an 8-week course that has been empirically tested with adults, has not been implemented with YA survivors and a telehealth modality is essential for reaching this geographically dispersed population. The purpose of this qualitative study was to describe themes that emerged from YA cancer survivors' participation in an 8-week MSC video-chat intervention. Methods: Nationally recruited posttreatment YA survivors (ages 18-29) were assigned to one of five video-chat study groups (N=25) and attended eight weekly 90-minute video-chat MSC sessions. Qualitative analysis were conducted on verbatim transcripts of the recorded weekly video-chat sessions for four study groups (n=19); one group did not consent to be recorded. We utilized descriptive qualitative analysis, in which a solo coder used provisional and descriptive coding methods and met with research staff to reach consensus on the codes and emerging themes. Results: Descriptive analysis resulted in five prevalent themes surrounding participants' cancer survivorship experiences in the context of learning MSC. These included non-cancer survivor versus cancer survivor peer relations, study participant social cohesion, body image, trust in health, and perceived benefits/challenges of developing MSC . Conclusion: Further development of MSC interventions for YA survivors that embed developing self-compassion with aspects of the cancer survivorship experience (body image, peer relations, trust in health) may support successful reintegration into life activities/roles after treatment completion.

No. 12

Functional Analysis of Schizophrenia Genes Using GeneAnalytics Program and Integrated Databases

Poster Presenter: Tharani Sundararajan, M.B.B.S.
Co-Authors: Merlin G. Butler, M.D., Ph.D., Ann M. Manzardo, Ph.D.

SUMMARY:

Background: Schizophrenia (SCZ) is a chronic debilitating neuropsychiatric disorder with multiple risk factors. Numerous research studies have supported the involvement of multiple complex genetic components in the causation of schizophrenia and other psychiatric disorders. Methods: We interrogated clinically relevant and susceptibility genes associated with SCZ reported in the literature and genomic databases dedicated to gene discovery for characterization of SCZ. We used the commercially available GeneAnalytics computer-based gene analysis program and integrated databases to characterize an updated master list of 605 SCZ genes and their weighed impact in tissues and cells, diseases, pathways, biological processes, molecular functions, phenotypes and compounds. Results: Genes for schizophrenia were predominantly expressed in the cerebellum, cerebral cortex, medulla oblongata, thalamus and hypothalamus and associated with other psychiatric/ behavioral disorders such as ADHD, bipolar disorder, autism and alcohol dependence. Other associated non-psychiatric diseases included neuroblastoma, colorectal cancer, Alzheimer's and late-onset Parkinson's disease, sleep disturbances, impaired co-ordination, abnormal spatial learning and inflammation. Functional analysis of the SCZ genes using the GeneAnalytics program identified glutaminergic (e.g., GRIA1, GRIN2, GRIK4, GRM5), serotonergic (e.g., HTR2A, HTR2C), GABAergic (e.g., GABRA1, GABRB2) and dopaminergic (e.g., DRD1, DRD2) receptor genes as well as calcium channel-related genes (e.g., CACNA1H, CACNA1B), solute transporter genes (e.g., SLC1A1, SLC6A2) and neurodevelopmental genes (e.g., ADCY1, MEF2C, NOTCH2, SHANK3) involved in major biological pathways and mechanisms associated with SCZ. Conclusion: Our approach to interrogate SCZ genes

and their interactions at various levels contributing to disease and pathogenesis should increase our knowledge and possibly open new avenues for therapeutic intervention. We acknowledge the support of the NICHD grant (HD02528).

No. 13

Second-Generation Antipsychotic Metabolic Monitoring: Are Differences Dependent on Patient Factors?

Poster Presenter: Robert M. Portley, M.D., M.B.A.
Co-Authors: Stephen McLeod-Bryant, Nicole A. Brenson

SUMMARY:

Background: While there are established guidelines for monitoring the metabolic side effects of second-generation antipsychotic (SGA) medications, clinician adherence with these guidelines remains suboptimal. This retrospective cohort study evaluated differences in demographic variables, psychiatric diagnoses, diagnosis of cardiometabolic illness, & substance use between patients who did and did not receive recommended metabolic monitoring, to better identify patients particularly at risk of having this component of their care neglected. Methods: A retrospective chart review included 1,025 unique admissions in one year who were discharged from an academic unit at a community-based hospital and prescribed a SGA at discharge. For each patient admission, records were reviewed from 3 months prior to their hospital admission through their discharge for the following items: weight, height, blood pressure, waist circumference, fasting glucose, fasting lipid panel, hemoglobin A1c, medical history. Statistical analysis compared patient-specific factors to whether or not they received laboratory and biometric monitoring of metabolic parameters recommended for monitoring. Results: This analysis included 1,025 admissions prescribed a SGA at discharge (mean age; 43.1, 65% male). 64% of patients had no metabolic monitoring during admission or within the previous 3 months of their admission, and 25% had monitoring results available. 27 patients were discovered to have undiagnosed Diabetes Mellitus by fasting glucose. Patients who were more likely to not to receive metabolic monitoring were black or African-American (72%) (p=0.002), had Schizophrenia (64%) (p<0.001), Bipolar Disorder (69%) (p<0.001), Other Psychotic Disorder (75%) (p<0.001), Anxiety Disorder (95%) (p<0.001), Opiate use (76%) (p=0.008), and previously diagnosed hypertension (53%) (p<0.001). 32% of admissions of patients with previously diagnosed type 2 diabetes mellitus did not receive metabolic monitoring. Conclusion: There are specific groups that are particularly at risk of receiving suboptimal rates of metabolic monitoring while prescribed a SGA, even within an academic inpatient facility. These patients are particularly at risk of not being monitored for iatrogenic consequences of SGAs. Directing clinical awareness to these groups in particular, and all patients of SGAs generally, could be a high-yield change to current clinical practice that could improve care and health outcomes for these patients.

No. 14

Patient Perspectives on the Use of Magnetic Resonance Imaging (MRI) for Research Studies in Pregnant Women

Poster Presenter: Michelle Zaydlin, B.S.

SUMMARY:

Background: There is early evidence that brain structure could change permanently across gestation in ways that promote caretaking behavior. Pre-/post-pregnancy gray matter volume changes were recently documented among primiparous mothers in areas that subserve social cognition—and these changes predicted postpartum maternal attachment (1). The use of brain magnetic resonance imaging (MRI) during pregnancy in future studies could accelerate translation of this knowledge into preventive interventions. However, while there are no known adverse effects of MRI (without gadolinium) to women or fetuses, brain MRI remains reserved for diagnostic indications in pregnancy (2), and patient perceptions are critical to consider. In this study, we surveyed a convenience sample of pregnant women about their concerns regarding participation in a hypothetical research study involving a brain MRI without gadolinium during pregnancy. Method: Data were collected from a larger anonymous survey study on prenatal smoking over a 7-week period (April-June 2017). Participation was offered to all women presenting for obstetric

care at 4 clinics across an urban Midwestern academic medical center campus (included privately- and publicly-insured patients). Questionnaires presented information in lay language about MRI during pregnancy, then inquired about women's willingness to participate in a hypothetical research study involving MRI during pregnancy (yes/no/maybe). Participants who answered 'maybe' or 'no' were asked to write what concerns they had and what, if anything, would increase their willingness to participate. The study was exempt from IRB review. Results: We collected 76 completed questionnaires. Respondents were pregnant women with a median age of 30-34 from diverse racial and ethnic backgrounds (41% non-Hispanic white; 11% Hispanic; 40% Black; 11% Asian/Pacific Islander). Close to two-thirds (62%) were multiparous and 37% endorsed lifetime smoking. Regarding willingness to participate, 28% (n = 21) responded 'yes;' 28% (n = 21) answered 'maybe;' and 43% (n = 32) responded 'no.' Narrative responses regarding concerns were health/safety (38%); time constraints (33%); general disinterest (23%), and being in a closed space (5%). Receiving more information, knowing that brain MRI were a "common practice" in pregnant women, and knowing that participation could "help another child" were cited as reasons that would persuade no/maybe respondents to participate. Conclusion: Many pregnant women in this sample would consider participating in a hypothetical research study involving brain MRI when queried anonymously. Focus groups could further elucidate concerns, critical to the design of ethical and effective patient education and recruitment materials. Funding. This study was supported by grant 5K23DA037913 to Dr. Massey from the National Institute on Drug Abuse. Disclosures: None to report.

No. 15

Treatment of Chronic Pain With Buprenorphine in a Veteran With Traumatic Brain Injury

Poster Presenter: Adekola Alao, M.D.

SUMMARY:

Case Presentation We report a case of a 27-year-old veteran who sustained severe traumatic brain injury (TBI) following a blast injury from an improvised explosive device. The patient subsequently suffered severe anxiety symptoms controlled only by combination therapy with benzodiazepines and venlafaxine. Even more disabling, the patient also experienced intractable headache and shoulder pain unresponsive to non-steroidal anti-inflammatory agents. Given the risk of respiratory depression with his current medications, opioid analgesics were not favoured. The patient was started on sublingual buprenorphine at a dose of 8mg three times daily with significant improvement. This dose was maintained and the patient was able to function relatively pain-free. Discussion Chronic pain is a significant complication in patients with TBI and is reported by a majority of patients with TBI, regardless of the severity of the injury. The treatment of chronic pain among individuals can be challenging as patients may be on other medications. Further treatment with narcotic analgesics may therefore increase the risk of respiratory depression. Buprenorphine is a partial mu agonist whose effects plateau at higher doses, at which time it begins to act like an antagonist. Buprenorphine thus has the advantage of effective analgesia with minimal sedation and may be useful for treating chronic pain among TBI patients already taking benzodiazepines. While clinicians should be aware of these possible benefits, more studies are necessary to evaluate the efficacy of buprenorphine among TBI patients with chronic pain.

No. 16

Seeing Double: Sertraline and Diplopia

Poster Presenter: Adekola Alao, M.D.

SUMMARY:

Introduction Sertraline is an antidepressant in the class of selective serotonin reuptake inhibitors (SSRIs), and along with the other SSRIs, it has become a mainstay in the pharmacologic management of major depression and related mood disorders. In this report, we describe a 34-year-old man who developed diplopia after treatment with sertraline. To the best of our knowledge, this is the first reported case of sertraline-induced diplopia. Case Report A 34-year-old male veteran with a history of PTSD and major depression stabilized on citalopram 20 mg daily. Due to a lack of efficacy after a year, the citalopram dose was gradually titrated down. After one week, the patient was started on

sertraline, 50 mg daily. Two days after his first dose of sertraline, he started having double vision, as well as light sensitivity. He stopped taking the sertraline, and these symptoms disappeared. The patient re-challenged himself with sertraline at a lower dose of 25 mg daily after 3 days and he had a recurrence of diplopia as well as blurred vision. Discussion Two cases of diplopia after citalopram ingestion have been reported in the literature. The acute onset of diplopia in this patient following sertraline treatment, in addition to the rapid resolution of the diplopia and reoccurrence after re-challenge indicates an association between this adverse effect and the drug. Although considered very safe, rare and serious ocular side effects of SSRIs, including angle-closure glaucoma have been reported. Receptors for serotonin have been discovered in the eye, strongly suggesting a functional role for this neurotransmitter in ocular tissue. Conclusion Although further research is needed to establish the cause of sertraline-induced diplopia, this case illustrates the importance of increased patient and physician vigilance for this possible adverse effect.

No. 17
WITHDRAWN

No. 18
"I Saw You Fixing the Cox Cable in My Apartment" Fregoli Delusion: A Disorder of Person Misidentification
Poster Presenter: Amarachi Nwaije, M.D., B.S.

SUMMARY:
Mr. B. is a 66-year-old, single, unemployed AA male with PPH of Schizophrenia and Cocaine use disorder in remission and PMH of HTN, who presented to the ER for treatment of a laceration he sustained after being hit with an unknown object on forehead. After laceration was treated, He was admitted to the psychiatry. Mr. B. reported symptoms of psychosis like delusions of Control stating he believed that people were controlling his bowel movements and urinary frequency leading to multiple bowel movements per day and urinary frequency. He also reported he felt like he was being chocked whenever he ate or drank. He also reported ideas of reference when he is watching TV. Mr. B. complained of "seeing people who look like me" and strongly believed they were him. Which cause him tremendous discomfort as he became isolative and withdrawn on the unit. During meal time he would go to the dining but would not eat any meals. He reported "when I go to sit at my tray, People look at me as if it is not my food, maybe someone else that looks like me." Whenever he was told his Vital signs, he would say "I not sure that is mine it appears to be another patient's who has my name and appearance." Usually pointing to someone else. He also reported prior to being in the hospital, he was living in an apartment where he was paying his bill consistently until he stopped as he felt like "there was something fishy going on and I started seeing other people's mail/bills coming in my name so I stopped paying the bills" therefore his utilities got cut off. He also reported he stopped paying rent as when he went to pay his rent one of the months, the lady appeared was someone different and didn't pay after wards leading to his eviction. The patient states to one of the nurse on the unit "I saw you on crutches at the store" and the nurse states he has never met the pt. before. He also reported seeing his niece at his local bank where and states "she didn't say anything to me, she just walked by." His son claims the niece would not be at the bank as she does not live close to the area. He also told the writer, "I saw you the cox cable in my apartment." He reported symptoms to be intrusive and bothersome. Treatment: The patient was started on Haldol 5mg and Titrated up to 10mg twice daily and Benztropine 0.5mg twice daily. The patient underwent a neurological work up, CT scan was done showed no acute intracranial abnormalities, MRI Brain w/o contrast performed and showed No acute intracranial infarct or mass effect however Volume loss, moderate microangiopathy and old lacunar infarcts within the right basal ganglia and right periventricular white matter. An EEG done was WNL without focal or epileptiform abnormalities. Fourteen days into his admission he was given Haldol Dec 150mg IM. His symptoms gradually started resolving and became less intrusive and bothersome. This case also underscores the need for psychiatrists to recognize this disorder, as its initial presentation may appear as if the patient is uncooperative/paranoid and disorganized or malingering to get out of responsibilities. Also, this syndrome ass. with Traumatic Brain Injury.

No. 19

Psychosis and Schizophrenia Spectrum Disorders Contributing to Legal Problems in Populations 50 and Older

Poster Presenter: Amarachi Nwaije, M.D., B.S.

SUMMARY:

Ms. A is a 55 y/o African American female with No past psychiatric history and past medical history of asthma. She was transferred to our hospital from jail for competency evaluation. Ms. A reports because she was arrested after she appeared at her previous place of employment and violated a restraining order. She denied any other legal history. She reports she was fired from job due to "bad conduct, low performance, inappropriate behavior, Ideations and signs of paranoia". Ms. A presented with commentary auditory hallucinations, Pt reports that her previous place of employment believed "she was an informant, leaking information to Capitol Hill" and that she hears the voices of her managers and the "investigators" at her former job continuously speaking to her. Thought insertion and broadcasting, She was fixated on "investigators" who installed a "mind control" on her without her permission for "surveillance." She denied depressive or manic symptoms. Treatment: Routine labs were drawn. Pt was worked up to r/o other causes of psychosis and Trazadone 50mg was started the first day. After labs were returned Ms. A was started on Risperdal 1mg BID. It was titrated up to Risperdal 2mg QAM and 3mg QPM, and Cogentin 1mg BID was added. Clinical Diagnosis: A provisional diagnosis of Unspecified Psychosis was made at Admission, after observation, she was given a diagnosis of Schizophrenia Late Onset After labs results ruled out primary causes. Current literature classify Late Onset Psychosis(LOP) as ages 40 to 59 and Very late Onset Psychosis (VLOP) >60 yrs. old. In patients with onset at age 45 years or later, visual, tactile, and olfactory hallucinations, third-person running commentary auditory hallucinations, and paranoid and partition delusions have been reported to be predominant symptoms, and negative symptoms such as affective flattening and formal thought disorder are less common. This report serves to increase our awareness of growing population of psychosis people who would have appeared to have productive life for years and may begin to show signs of "psychosis" which can be first detected by the legal system through problems at work or with family as disorganized behavior may became more apparent.

No. 20

Philadelphia Alternative to Forensic State Hospitalization Model: Evaluation Based on Public-Academic Partnership

Poster Presenter: Christina D. Kang-Yi, Ph.D.
Co-Authors: Christy L. Giallella, Ph.D., Katie M. Nikolajuk, Na Young Kim, Jac Rivers, Katy M. Kaplan, Ph.D., Aelesia E. Pisciella, Ph.D., Shakira Williams, M.B.A., Trevor R. Hadley, Ph.D., David S. Mandell, Sc.D.

SUMMARY:

Unreasonable wait time for forensic treatment for competency restoration has been a great concern across the United States. These prolonged wait times are costly due to the additional cost of care for IST inmates while they await inpatient treatment and legal actions due to unreasonable wait time for inpatient transfer. The lack of systematic coordination and monitoring of the incompetent to stand trial (IST) cases has resulted in unreasonable wait time for forensic treatment for competency restoration, lack of competency restoration and lack of recovery-oriented community treatment designed for those who cannot be restored to competency. The wait time for inpatient forensic treatment in Philadelphia is at the longer end of these national trends. To improve efficiency of competency restoration and recovery-oriented community psychiatric care for individuals with IST, Philadelphia's Department of Behavioral Health designed the Philadelphia Alternative to Forensic State Hospitalization Model. This program will: (1) identify facilitators and barriers to improving the efficiency of current IST case management practice; and (2) improve recovery-oriented community psychiatric treatment for individuals with IST being discharged from a state hospital forensic care unit. The City Philadelphia Department of Behavioral Health and Intellectual Disability Services, Community Behavioral Health and the University of Pennsylvania Center for Mental Health Policy and Services Research have partnered to estimate the

impact of the Philadelphia Alternative to Forensic State Hospitalization Model on efficiency of IST forensic care coordination and recovery-oriented community psychiatric treatment for individuals with IST discharged from the state hospital forensic care unit. This poster presentation introduces the partnership-based evaluation formation and process. The processes of the program evaluation has led the public-academic partners to learn the importance of (1) facilitating communication between clinical and research/evaluation teams, systems of care such as the behavioral health system, the jail system and community service providers; and (2) designing creative ways of encouraging service providers to collect good quality of primary data and utilize the data for service improvement. The presentation will introduce how evaluation process has informed and address future directions for public-academic partnership to further forensic behavioral health services for people entering jail with psychiatric disorders.

No. 21
Euthanasia and Physician-Assisted Suicide: A Forensic Psychiatric Perspective
Poster Presenter: Zain Khalid, M.D.

SUMMARY:
Euthanasia and physician assisted suicide (EAS) remain subjects of heated controversy among physicians, patients and the general public. Even as efforts toward legalization in the US and abroad have made recent gains, ethical issues of autonomy, dignity, professional obligations and integrity, protection of vulnerable patient populations including the mentally ill, and concerns about potential for abuse and 'slippery slopes' continue to divide opinion. This review summarizes these ethical concerns in the context of relevant landmark cases and recent legislative efforts in the US and abroad. It also comments on the expanding role of forensic psychiatrists, particularly in establishing robust standards of competence to consent for EAS, and in otherwise facilitating the decision making process. Evolving attitudes and practices among psychiatrists, professional organizations and the general public are also considered. Finally, an emerging need for greater training of psychiatrists in end of life issues, with particular emphasis on the legal and ethical issues surrounding EAS is discussed.

No. 22
The Making of ADHD Nation
Poster Presenter: Saeed Ahmed, M.D.
Co-Author: Sanya Virani

SUMMARY:
This is a case of a 25-year-old male, high school graduate, “Mr. A.” brought into Psychiatric emergency presented unkempt, anxious, and a bit hostile, psychotic with paranoid delusions and auditory-visual hallucinations. After abandoning his car somewhere, he had gone missing, and exasperated family members filed a missing person complaint. Two days of mysterious absence returned to his family, declaiming God had ordered him “to go to Brooklyn Navy Yard to join MI-6,” the British Intelligence Agency, and that he had immediately taken the subway there. The brief but bizarre proclamations emanating from their son shocked his parents because ideas such as these had never come from him. Mr. A. thwarted our initial attempts to talk with him by simply nodding his head when we provided the option to talk later. The following day, he broke down and was inconsolable. As his hands quivered and he fidgeted in his chair, he slurred, “I want to quit. . I tried but I couldn’t. . . I am ashamed of myself.” He mumbled, “Adderall.” Mr. A. admitted first experimenting with the drug during high school, after being introduced to this “smart pill” by his friends, who often took it to excel in classes. His few-times-a-month dosing gave way to a few-times-per-week, until he became fully addicted, and was using it to get high. Chasing the dragon of his addiction, and anxious he would run out of pills, he sought it from friends and sometimes the streets. The source did not matter; Mr. A. went so far as to feign illness, by researching and mimicking the Attention deficit/hyperactivity disorder (ADHD) symptoms and present himself as a textbook case of ADHD to a psychiatrist to secure a renewable prescription. The case of Mr. A. illustrates six troubling issues associated with prescribing Psychostimulant Drugs, misdiagnosis, inappropriate stimulant prescription, the resulting addiction, untoward side effects, serious social consequences, and, when the numbers are extrapolated, an increased economic burden.

What should be extremely crucial is for clinicians to conduct a thorough evaluation before making the appropriate, non-pressured, correct diagnosis, or even considering prescribing a medication as a first resort. It is simple: understanding the disorder and constructing the appropriate diagnosis should target, as a rule, the appropriate treatment.

No. 23

A Case of Huntington's Disease With Neuropsychiatric Complications

Poster Presenter: Saeed Ahmed, M.D.

SUMMARY:

Huntington's disease (HD) is an autosomal dominant neurodegenerative disorder which is manifested with cognitive, motor and severe Neuropsychiatric manifestations commonly anxiety, irritability, dysphoria, agitation, depression, obsession and compulsions, and psychosis. Estimates of the prevalence of neuropsychiatric symptoms in Huntington's disease are between 33 to 76 percent of patients. Historically neuropsychiatric illness in Huntington's disease, we do not have any clear guidelines or protocol, there are many available options but due to adverse of medications like the risk of depression and suicidality make it more complicated to use these medicines. We present a case of the 42-year-old white female, single, homeless, with past medical history of Huntington's Disease, progressive dementia secondary to Huntington's Disease, Seizure Disorder. She has an extensive Psychiatric history of polysubstance abuse disorder, Major Depressive Disorder, and Borderline Personality Disorder. She has a prior history of more than 30 hospitalizations, multiple suicide attempts, admitted to Psychiatry service for active suicidal ideations with serious intention and planned to overdose on Heroin. This case study is novel in the literature; we discuss the clinical challenges faced by clinicians while managing such cases in the absence of clear guidelines.

No. 24

Dextromethorphan (DMX)-Induced Mania

Poster Presenter: Saeed Ahmed, M.D.

SUMMARY:

Dextromethorphan (DMX) is an ingredient frequently found in over-the-counter cold and cough medication, pharmacologically active as an isomer of codeine, utilized for cough suppression. At supratherapeutic dosages it acts as a nonselective serotonin reuptake inhibitor, a sigma-1 receptor agonist, and a NMDA receptor antagonist, resulting in dissociative and stimulant effects at higher doses (>240 mg). At high doses of DXM produce PCP-like behavioral effects much similar to the state of "drug-induced psychosis". DXM hold the potential for abuse, also used as the recreational drug, commonly known with street names as Red Devils, CCC, triple c, robo, skittles, and poor man's PCP. We present a case report of a middle age medical professional, with a prior diagnosis of bipolar disorder, who presented in an acutely manic state, precipitated by over-utilization of DMX. The case is novel in the literature in that the stated purpose of using excessive amounts of DMX was to purposely self-medicate mood symptoms and titrate dosages with DMX to achieve and maintain a 'functional' hypomanic state. Published literature and evidence shows that Psychoactive symptoms are dose related and symptoms range from intense anxiety, cognitive impairment, insomnia, paranoia, delusional beliefs, extreme agitation, visual and auditory hallucinations, and euphoria. This unusual case illustrates diagnostic and treatment challenges, clinical implications of abuse of over-the-counter cough syrup DXM, particularly in a patient with prior history of Bipolar Disorder.

No. 25

Understanding Gut Fermentation Syndrome in the Psychiatric Evaluation of Patients With Suspected Alcohol Use Disorder

Poster Presenter: Jacob R. Wardyn

SUMMARY:

Gut Fermentation Syndrome, also known as auto-brewery syndrome, is phenomenon not well understood in today's medicine with few articles discussing its etiology, presentation, diagnosis, and treatment. The literature describes Gut Fermentation Syndrome as patients becoming intoxicated without the ingestion of alcohol. The hypothesized mechanism is from overgrowth of certain yeast in the gut that allows for fermentation of complex carbohydrates, especially after high

carbohydrate meals. This creates an interesting dilemma for doctors when beginning evaluation of patients with alcohol use disorder as this rare syndrome could be used as a defense for a patient's apparent alcohol use. As was recently seen on our psychiatry consult service, the patient stated an abstinence from alcohol use and that auto-brewery syndrome was the cause of the continually elevated blood alcohol levels. Therefore, it is paramount to know the typical presentation seen, the possible diagnostic studies available, and typical effective treatment when presented with this clinical scenario. Having this understanding would allow for the psychiatrists involved to give a more thorough recommendation.

No. 26

Developing Interest in Psychiatry Careers Among Medical Students

Poster Presenter: Simran Brar, M.D.
Co-Authors: Kanakadurga Meyyazhagan, M.D., Glenda L. Wrenn, M.D., M.S.H.P.

SUMMARY:
Introduction: The shortage of Psychiatrists in the United States continues to be a problem especially within urban underserved and rural communities. Over 50% of Psychiatrists in the Georgia are currently over the age of 55. In addition about 26% of the psychiatric residency slots in 2015 were filled by international medical graduates; who often help address population disparities by practicing in shortage areas. Although the American Association of Directors of Psychiatry Residency Training (AADPRT) Recruitment Committee is charged with promotion of psychiatry careers, little empirical evidence exists on effective strategies to increase U.S. medical student interest in the field of Psychiatry. The goal of this project is to learn which medical school based events have greater impact on medical students' interest in Psychiatry. Methods: In the proposed study, researchers will work with Morehouse SOM medical students who are currently voluntarily participating in the Morehouse 'Psychiatry Interest Group' to better assess medical student interest in the field of Psychiatry and co-design activities to promote interest. The researcher team will meet with the Psychiatry Interest Group who will host monthly events over the course of six months (may include "psych cinema", Q&A sessions with seniors or attendings on topics of interest, and other educational activities). Surveys will be developed in RedCap and administered before and after each monthly event, and participants will be asked to indicate which prior events they attended. The data from the surveys will be analyzed using statistical software. Expected Results: A preliminary survey was developed and key assessment domains will be presented. An increase in interest amongst medical students after their attendance of monthly events over the course of 6 months is expected. Conclusion: Events that are co-developed with and conducted within a Psychiatry interest group can be a useful career recruitment method. Event surveys will help tailor the program to better suit the interests of medical students. As interest in Psychiatry among medical students rises, more students will apply for Psychiatry residency programs and help address pressing workforce issues.

No. 27

“I Will Kill Myself… If You Discharge Me!” Complexities in Clinician Decision Making in a Case of Suspected Conscious Simulation

Poster Presenter: Catalina Trevino Saenz, M.D.
Co-Authors: Sina Shah-Hosseini, M.D., M.S.E., Raj Addepalli

SUMMARY:
This is a case of a 42 year old Hispanic male with past psychiatric history of self-reported depressed mood and suicidal ideation and multiple inpatient admissions for similar complaints who presented to the Psychiatric Emergency Service complaining of command auditory hallucinations to kill himself. He reported conditional suicidal ideation and made a suicidal gesture to hang himself in the context of imminent discharge from the Emergency room. The patient reported history of daily cocaine use last use one month prior to hospital arrival, history of incarceration for 16 years and non-adherence to home psychiatric medication which included an antipsychotic. Upon admission to the inpatient unit the patient was restarted on home medications and presenting symptoms had resolved within hours of his initial evaluation. Once resolution of symptoms was sustained for three consecutive days and

medication compliance was maintained, patient again expressed conditional suicidal ideation in the context of his imminent discharge from the inpatient unit. Review of the psychiatric history indicated that he was last discharged from the inpatient psychiatric unit 8 days prior to current admission. Patient had a history of multiple psychiatric inpatient admissions resulting from nearly identical presentation. Contact with his outpatient treatment providers indicated difficulty in addressing the veracity of his suicidal threats and subsequent referral to the Emergency room to address his threats. Subsequent testing on the MMPI-2 inventory and M-FAST (Miller Forensic Assessment Test) revealed a profile highly suggestive of malingering. He endorsed extreme symptoms, rare combination of symptoms, unusual hallucination, unusual symptom course, and demonstrated suggestibility to unusual items. This case highlights the default in discerning the true intentions of patients who consciously feign their symptoms especially of a suicidal nature and subsequently result in inpatient admissions which use up valuable inpatient beds and tie up scarce mental health resources. Absence of a reliable tool to accurately assess seriousness of suicidal gestures and intent leads to hesitation on part of clinicians to discharge patients who may not require inpatient admission and also lead to counter transference of treatment providers in addressing the actual needs of these patients. Medicolegal implications of ignoring suicidal threats and gestures which may lead to inadvertent accidental suicide need to be considered. Long term engagement of these patients will be needed to effectively address their intentions of illness feigning behavior.

No. 28

Life After Residency: Making the Next Move

Poster Presenter: Kevin Malee

SUMMARY:

• Creating the attractive CV & how best to present yourself on paper: First impressions are key and your CV will tell others about you and what you have accomplished. • Where to begin my career search: Recruiters, agencies, federal & state program all can assist, but I must know where I want to begin. • Searching for the right practice: Traditional, primary care or hospital medicine - how to decide and what am I looking for? • Location, location, location: Geography and where I search is as important as much as my practice and colleagues. • Compensation packages: MGMA & my colleagues can assist me in finding the best package, loan repayment, sign-on other benefits. • The site visit & key questions I need to ask: Asking the right questions, finding the right answers. • The Contract: What to look for and when to be cautious. • Move & relocation questions: Asking all the right questions to avoid confusion and disappointment. • Finding a mentor: Key to success in finding a mentor, what to look for and how to find. • Starting my career: All the ingredients to starting my career, life, family and all the rest.

No. 29

Family-Centered ECT Care

Poster Presenter: M. Justin Coffey, M.D.

Co-Authors: Kristina Bullard, M.S.N., R.N., C. Edward Coffey, M.D.

SUMMARY:

In 2001 with the publication of its groundbreaking report Crossing the Quality Chasm, the Institute of Medicine (IOM) issued a clarion call for health care to be centered on the patient. We began using its "10 Simple Rules" as a roadmap for transforming the care of his ECT Service at a major teaching hospital. A key strategy in this transformation was to partner with patients and their families in the design and assessment of the ECT care. This strategy included routinely providing our patients the option to be accompanied by family members and significant others into the ECT treatment suite to observe and participate in the procedure (from preop to treatment to recovery). Over the next decade we refined this patient-centered approach and learned a great deal from its application to ECT care. During this time, nearly all patients preferred to have a family member or significant other in the ECT treatment suite during one or more procedures. The lessons learned from the focus group followed five key themes. First, the presence of family members in the ECT treatment suite relieved anxiety for both the patient and family members and strengthened their trust of the ECT team. Second, participating in the ECT treatment enhanced family members' overall engagement in the patient's mental health care.

Third, participating in the ECT treatment empowered family members to improve both pre-ECT care (e.g., ensuring adequate hydration for more comfortable venipuncture) and post-ECT care (e.g., assisting in post-ictal reorientation). Fourth, the presence of family members in the ECT treatment suite enhanced communication among providers (e.g. between the psychiatrist and the anesthesiologist). And fifth, participating in the ECT treatment empowered family members to serve as ambassadors against stigma. As these lessons have been shared, several institutions have adopted and implemented this family-centered approach to ECT care. Based on these incredibly positive experiences, we offer this poster presentation to IPS attendees and encourage them to engage their ECT patients in a conversation about how family members or significant others might become involved in ECT care processes.

No. 30

Pursuing Cultural Competence at the Organizational and Clinical Levels: A System-Based Model Applied to a Community Center in NYC

Poster Presenter: Pamela C. Montano, M.D.
Co-Authors: Xiaojue Hu, M.D., Hunter L. McQuistion, M.D., Diana Chen, Ph.D., Giselle Plata, M.P.H., Diana Acosta, M.D., Dustin Chien, L.M.S.W.

SUMMARY:

Introduction: In a globalized world, the development of culturally responsive care in mental health treatment is vital. Examples of the implementation of culturally competent care in diverse community settings are lacking in the literature. Examples of barriers to implementing such care and their potential solutions have also not been widely discussed. As an urban outpatient community clinic situated in the multicultural Lower East Side neighborhood in New York City, Gouverneur Behavioral Health is an example of a place where culturally competent care was developed and implemented before such terms were defined. It contains two sub-clinics – the Asian Bicultural Clinic (ABC) and Latino Bicultural Clinic (LBC) – that has adapted treatment to its diverse clientele. This project assesses the cultural competence (CC) of the entire clinic on multiple levels, focusing on examining strengths and areas of improvement. Methods: Demographic data was gathered about the clinic's patient population by analyzing its patient database. The NKI Agency/Program Assessment Tool was conducted with 27 senior staff members to assess the CC of the clinic at an organizational level. The Iowa Questionnaire was conducted amongst 200 patients to assess their perception of CC. Provider-level questionnaires were conducted to assess the CC of providers themselves. Structured interviews were conducted with 25 clinicians focusing on the clinic's histories, and the perceived barriers to and strategies adopted to increase CC. Results: Clinic demographics revealed a female majority (62.5%) with self-identified race and ethnic categories composed of 44% Hispanic, 25% Asian, 12% Non-Hispanic White and 6% Non-Hispanic Black. NKI scale revealed organizational strengths including matching culturally and linguistic trained staff to its patient population, while areas of improvement included a lack of such staff in administration. The Iowa Questionnaire results included patient satisfaction with the availability of staff who understood their cultural background, while some patients felt there could be a higher level of community outreach from the clinic. Provider questionnaires revealed a heterogeneous level of CC among staff, with higher levels of CC with staff affiliated with ABC and LBC. Interviews with staff elucidated such clinical barriers to care as a high stigma against mental health and a tendency to present psychiatric symptoms initially to non-psychiatric providers in both the Chinese and Latino populations. Structural barriers included challenges in developing cohesion among staff with heterogeneous cultural backgrounds. Strategies adapted to increase CC care included close coordination between staff and family, between staff and community and agencies, and between staff members and the administration. Discussion: The clinic has strengths in such areas of CC as having staff whose cultural and linguistic backgrounds match those of the prevalent client groups, as well as on the emphasis in forging relationships amongst patients, staff, and organizations. Areas of improvement include paying attention to other demographic information (such as the LGBT community), the integration of the ethnic sub-clinics within the clinic as a whole, and improvement of cultural training for all staff. Cultural competence is a process, not a definite end point. Improvement

requires the on-going evaluation and monitoring of services on multiple levels to ensure an equality of access and quality of treatment for the populations we're dedicated to serve.

Rapid-Fire Talks

Thursday, October 19, 2017

Rapid-Fire Talks: Focus on Community Collaboration

No. 1
Connecting Coordinated Specialty Care Teams for the Treatment of First-Episode Psychosis With Their Communities
Presenter: Iruma Bello, Ph.D.
Co-Authors: Liza Watkins, L.M.S.W., Lisa B. Dixon

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Discuss implementation challenges and strategies for integrating coordinated specialty care services into the mental health spectrum of services and community; 2) Understand strategies for training providers to conduct outreach and recruitment activities to enhance access to the service; and 3) Describe key methods for monitoring the quality of team outreach activities.

SUMMARY:
Background: Coordinated specialty care (CSC) is a multi-element, multidisciplinary team-based model now considered the evidence-based approach for individuals experiencing early psychosis. Given that shorter duration of untreated psychosis is associated with better outcomes, one of the challenges in CSC implementation efforts has been optimizing a referral pathway. OnTrackNY is New York State's CSC program. **Objective:** We will describe the expansion of CSC services in New York State (NYS) and how OnTrackNY teams build community connections to optimize the referral pathway. We will also describe the framework for training and monitoring outreach and recruitment coordinators (ORC), who conduct outreach to potential referral sources, rapidly process referrals, and evaluate clients for eligibility. **Methods:** The NYS Office of Mental Health expanded from four CSC programs in late 2013 to 18 by October 2016 and established a technical assistance team to ensure quality. Implementation challenges have included lack of community knowledge about the availability and rationale for OnTrackNY services. NYS's technical assistance framework facilitates the adoption of strategies for increasing the number of a team's community connections and referrals received. **Results:** In October 2016, 17 OnTrackNY teams were open to referrals, each with an ORC. New ORCs receive biweekly individual consultation calls for three months, followed by monthly individual and learning collaborative calls to enhance skills in linkage to and tracking of referral sources, in addition to building engagement and evaluation skills. OnTrackNY teams have received 1,206 referrals since July 2015 and enrolled 273 clients. Referrals came from varied sources, with 22% from a mental health outpatient provider, 41% from inpatient units, and 23% self-referred or referred by a family member. An additional three percent came from community organizations and emergency rooms, with one percent coming from schools. The average time from the onset of psychosis to enrollment was 7.4 months. **Conclusion:** OnTrackNY ORCs demonstrate an ability to establish community relationships and facilitate the early identification and referral of young people experiencing psychosis. However, a preponderance of OnTrackNY referrals still come from inpatient units, and the time from development of symptoms to CSC treatment remains over seven months. Challenges in establishing a diverse network vary by host setting and community, and clinicians are often new to conducting outreach. As such, individual and group consultation over time is needed so that new CSC programs can become flexible and responsive to the community's needs and reduce delays in connecting to optimal treatment.

No. 2
Recovery From Serious Mental Illness Through a Novel Mobile Community Navigation Program: "Opening Doors to Recovery"
Presenter: Luca Pauselli, M.D.
Lead Author: Michael T. Compton, M.D., M.P.H.
Co-Author: Beth Broussard

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant

should be able to: 1) Define the opening doors to recovery (ODR) model; 2) Describe the importance of community navigation to recovery support; and 3) List two types of community partnerships that make mobile delivery of the ODR model possible.

SUMMARY:

Part of Rapid-Fire Talks: Focus on Community Collaboration

No. 3

How to Start a Collaborative Care Program in an Academic Primary Care System: Vision, Resources, Business Plan, and Early Experience

Presenter: L. Lee Tynes, M.D., Ph.D.
Co-Authors: Angela Gourney, R.N., Katherine Taylor, L.C.S.W., Alvin F. Smith, L.C.S.W., Brandon Michel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the multidisciplinary leadership cast that should create and organize around the vision for an integrated care program in an academic environment; 2) Appreciate the initial resources required for planning such an integrated care program; 3) Enumerate the essential aspects of a business plan to create the program; and 4) Understand the initial steps in a rollout of a collaborative care program.

SUMMARY:

Integrated care programs have recently received much publicity owing to their potential to address depression and other mental health problems within the primary care setting, bringing improved psychiatric outcomes, reduced health care expenditures, and higher patient and provider satisfaction. Sophisticated research programs bring resources and expertise to the participating primary care practices not commonly available to most clinic systems, though a growing number of web-based and didactic resources are available to interested parties. Examples include the AIMS center (https://aims.uw.edu), SAMHSA programs (www.integration.samhsa.gov), support materials from the COMPASS multisite study (COMPASS Toolkit 2015), recent texts (Raney, 2015), and the APA-sponsored training in integrated care, supported by a CMS TCPi grant. LSU Health Baton Rouge, a division of Our Lady of the Lake Hospital, comprises five primary care clinics staffed by 17 faculty physicians, 40 residents, and nine nurse practitioners seeing over 31,000 patients annually. The Mid-City Clinic, the pilot site, sees over 10,000 patients annually, with about 980 patients maintaining a diagnosis of depression and/or anxiety, though many cases may go unrecognized. The authors present the first in a series of "how-to" presentations addressing the real-world challenges of creating, maintaining, and growing a collaborative care program in an academic hospital-based primary care clinic system. This first presentation covers the authors' initial exploratory and organizational sessions, initial conceptualization and creation of the vision, resources felt to be most helpful, and the steps to create a business plan. The planning steps for ramping up the behavioral health workforce and the associated training will be reviewed. The education of non-program clinicians will also be presented. Baseline (pre-implementation) data collection will be detailed, along with the process to determine workflow. The authors conclude with a reflection on early experiences, the roll-out process, lessons learned, and preliminary descriptive data.

Friday, October 20, 2017

Rapid-Fire Talks: Focus on Early Childhood Interventions

No. 1

Moving Upstream in a Coordinated Care Organization: Incorporating ACEs

Presenter: Maggie Bennington-Davis, M.D., M.M.M.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn how studying high utilization of health care is related to upstream and early life factors; 2) Translate maternal and early childhood experiences into health services; and 3) Consider integration as primary and secondary prevention.

SUMMARY:

Health Share of Oregon is one of Oregon's coordinated care organizations, which coordinates

mental health, substance use disorder (SUD) treatment, oral health, and physical health services for over 200,000 Medicaid members. In studying high utilization of health services, Health Share conducted a life experiences survey, which showed that early childhood experiences translated into later adult adverse experiences, chronic illness, SUD, and high health care needs and costs. High adverse childhood experiences (ACEs) have long been linked to "health behaviors" having specific biological risks for disease--such as tobacco or injection drug use or lung or liver disease--but high ACEs have also been shown to have social consequences with their own health impacts. Increased rates of high school non-graduation, incarceration, and homelessness are all associated with increased ACEs. Other risks to social function linked to ACEs include problematic kindergarten behavior, literacy, and academic performance; teen pregnancy and associated family, financial, job, stress, and anger problems; and sexual victimization in adulthood. Understanding what else beyond ACEs happens to people as they grow into adulthood and where social as well as clinical interventions may change a life trajectory is key in addressing the population health consequences of early adversity. Health Share subsequently invested in "upstream" services that could assess for and address social determinants of health and integrate mental health, SUD treatment, and primary health care in maternal and early childhood programs. These programs include ensuring access to effective contraception, screening for social risk factors in pregnant women, using a specific approach in collaboration with the Department of Human Services for substance-dependent pregnant women, collaborating with community-based programs to ensure kindergarten readiness, and the development of foster child medical homes. All of these programs rely on the integration of mental health, substance use treatment, and primary care in order to adequately prevent the impact of adverse experiences. Each of these programs will be briefly described during this rapid-fire talk.

No. 2

Innovation in Early Intervention: Collaborative Approaches to Early Childhood Mental Health in Pediatrics

Presenter: Mary Margaret Gleason, M.D.

Co-Authors: Matthew Biel, Elise Fallucco, Leandra Godoy, Melissa Middleton, Anna Kelley

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the rationale for increasing attention to early childhood mental health in the primary care setting; 2) Recognize the range of early childhood mental health consultation approaches in pediatric primary care; and 3) Describe the common barriers related to access to early childhood mental health services.

SUMMARY:

Objective: Present three models of early childhood mental health collaborative care in pediatric primary care. **Background:** Collaborative approaches to primary care offer the opportunity of early identification, improved access, and higher quality care. Collaboration focused on very young children (0-5 years old) offers the earliest possible opportunities for identification and intervention, with substantial potential for preventive mental health, early identification, and improved access to specialty services when needed. However, few pediatric primary care providers (PCPs) are comfortable with these issues. Strikingly, studies of the most prominent pediatric consultation models report few consults focused on young children, who represent a high proportion of pediatric visits. Young children need developmentally specific collaborative care. **Methods:** This presentation will describe the development of three models of collaborative early childhood mental health (ECMH) care in pediatric medical homes. **Results:** We will present a needs assessment in an urban area from which two innovative models of identified gaps were developed in an urban setting. In this urban area, 100% of respondents (N=50) endorsed high levels of unmet need, and 79% reported low comfort and knowledge related to ECMH. From these findings, two models were developed: 1) mobilization of a citywide child psychiatry access program focused on ECMH and 2) a colocated ECMH team to serve families with young children. We will present an established model of screening promotion in pediatric primary care. The model employs didactics and clinical consultation to support PCPs. After a six-month pilot, 70% of providers reported screening at most well child visits

(versus four percent at baseline; p=0.0001), and billing claims data showed similar patterns (0.1% to 32.3%, p=0.0001). To address PCP concerns about time required for screening, efforts to shorten the screening measure while maintaining validity resulted in a screen with 89% sensitivity and 85% specificity predicting psychiatric diagnosis. We will present an interdisciplinary consultation model for children 0-5 that offers onsite consultation, phone consultation, and remote consultation to PCPs in academic and community settings. The central principles of the model include a strength-based approach, modified common factors, effective communication skills, and emphasis on accessible, concrete information for families. Compared to baseline, at one year, active providers had more comfort managing ECMH issues ($p<0.005$) and higher frequency using ECMH approaches ($p<0.05$).
Conclusion: Each model of integrated care offers developmentally specific, innovative approaches to promote ECMH, shaped by the needs of the community. Pediatric primary care presents an ideal setting in which to identify and address ECMH and caregiver concerns that have lasting effects.

No. 3
Development of a Psychiatry Mini-Rotation for Pediatric Interns
Presenter: Sarah Y. Vinson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Review the rationale for child psychiatrist involvement in pediatric resident education; 2) Discuss the development of a psychiatry mini rotation for pediatric interns at Morehouse School of Medicine; and 3) Identify ways in which technology can be leveraged to maximize the time of part-time and volunteer faculty.

SUMMARY:
With high demand for the treatment of child mental illness and a pronounced shortage of child psychiatrists, pediatricians are frequently met with mental health chief complaints. In fact, mental health conditions are among the most common chronic medical conditions treated by general pediatricians. In many areas of the country, referral to specialty services may result in delays in evaluation and treatment. In some, referral is not even possible, as there are no practicing child psychiatrists nearby. Pediatric residency presents an opportunity during a critical period of learning and professional development during which pediatric interns can be prepared and primed to provide basic mental health assessments and, when appropriate, to initiate treatment. Academic centers often house both pediatrics and psychiatry training programs; however, interdisciplinary collaboration is not as commonplace as the population needs demand. Through collaboration with pediatric colleagues, particularly during pediatric residency training, child psychiatry faculty have the opportunity to broaden their influence and to help address mental health disparities, albeit indirectly. Demands on the time of faculty, particularly if faculty are volunteer or part-time, and funding limitations can be perceived barriers to the development and implementation of such educational programming. By leveraging strategic alliances with community partners and using technology to increase the efficiency of face-to-face time and manage communication with rotation sites, trans-discipline mini rotations can be achieved with relative ease. In this presentation, the creation and ongoing development of a child psychiatry mini rotation directed by a part-time child psychiatry faculty member with a secondary appointment in pediatrics will be discussed.

Rapid-Fire Talks: Focus on New Models of Care

No. 1
Cutting-Edge Telepsychiatry: Tele-Teaming, Store and Forward, and In-Home Care
Presenter: Jay H. Shore, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Learn about evolving models of care that involve telepsychiatry—live interactive videoconferencing; 2) Examine how telepsychiatry can be used to blend care teams between and within sites of care; 3) Become familiar with the concept, workflow, and design of store and forward telepsychiatry; and 4) Understand how telepsychiatry can provide care directly into a patient's home.

SUMMARY:
Live interactive videoconferencing in psychiatric care—telepsychiatry—is a rapidly expanding model of care that increases access and quality of care to patients. Telepsychiatry is not only helping innovate the locations where treatment is received but also the structure and models of treatment being delivered. This talk will review and describe three evolving models of psychiatric care: tele-teaming, store and forward telepsychiatry, and in-home telepsychiatry. Tele-teaming involves creating teams of care between and within locations of care, blending virtual and in-person interactions to enable team-based care. Tele-teaming will be illustrated with examples drawn from residential alcohol treatment and integrated care. Store and forward telepsychiatry is a system that allows asynchronous patient data capture to facilitate asynchronous psychiatric consultation. Telepsychiatry has been increasing care directly provided to patients in their homes with a range of mental health treatments. After presenting the three models, the talk will conclude with an examination of how telepsychiatry in general can shift models of care delivery to improve access and quality and address cost and value for the health care system.

No. 2
Collaborative Care: Evidence-Based Mental Health for Primary Care Settings
Presenter: Anna Ratzliff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) List the Collaborative Care principles; 2) Describe the evidence-based for Collaborative Care; and 3) Name the key points of the business case for Collaborative Care.

SUMMARY:
Faced with national shortages of mental health professionals, communities need new ways to deliver effective mental health care. Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving healthcare reform landscape using integrated care approaches, in which mental health is delivered in primary care settings. In Collaborative Care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide mental health care. This session will discuss the evidence base and core principles of Collaborative Care. The business case and new payment options for Collaborative Care will also be reviewed.

No. 3
An Overview of the Project ECHO Model for Child and Adolescent Mental Health
Presenter: Steven Adelsheim, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Name three components of the ECHO model; 2) Understand multiple settings in which the ECHO model might best apply for their community; and 3) Consider strategies for addressing some of their local challenges in implementing ECHO model programs.

SUMMARY:
We know that half of all mental health conditions begin by age 14, and three-quarters by the age of 24. While 20% of adolescents may face a mental health diagnosis, 79% of this group ultimately don't access care. At the same time, the national shortage of child and adolescent psychiatrists and mental health providers continues across the United States. Unfortunately, the need for expanded support for those in schools, primary care, and other community settings in addressing the mental health needs of children, youth, and their family appears to be increasing. Project ECHO is an innovative model that shows great potential by increasing the capacity for partners in health and educational settings to recognize the mental health needs of young people in their communities and link them to early supports. Through the learning loops of the ECHO model, participants can present patients from their community settings to a multidisciplinary team of experts and their regional partners to receive guidance and support in how to best provide treatment to those in their home setting. Through the interactive discussion process, all participants gain knowledge, experience, and confidence in managing patients with similar clinical issues. For the provider or professional working in isolation,

knowing that the ECHO team is available for support allows for increasing comfort in initially addressing the individual child's needs, with the knowledge that backup support and consultation are readily available. With the support of the ECHO team, local providers progressively learn how to manage more complex clinical situations, increasing the local capacity for effective treatment. This presentation will focus on examples of the use of the ECHO model to support young people in primary care and educational settings. Additional considerations for and challenges with the use of telehealth consultation will also be discussed.

Sunday, October 22, 2017

Rapid-Fire Talks: Focus on Criminal Justice Collaborations

No. 1
It's My Trauma, Too: Debriefing Groups to Help Psychiatrists Process Traumatic Community Events and Address Compassion Fatigue in Baton Rouge, LA
Presenter: Eva Mathews, M.D., M.P.H.
Co-Authors: Deonna Dodd, M.D., Shanique Ampiah, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Define compassion fatigue; 2) Consider debriefing groups as a tool to help mental health providers process community trauma; and 3) Offer suggestions for mental health providers in other communities should they experience traumatic community events.

SUMMARY:
Part of Rapid-Fire Talks: Focus on Criminal Justice Collaborations

No. 2
Tragedy in the Sanctuary: The Charleston Community's Response to the Emanuel AME Massacre
Presenter: Deborah S. Blalock, M.Ed., L.P.C.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Demonstrate the knowledge needed to create instant access to care in a manmade disaster; 2) Understand the absolute need to address culture in a care delivery system; and 3) Address the needs of a clinical support team as it responds to a disaster.

SUMMARY:
On June 17, 2015, a self-avowed white supremacist joined 12 members of Charleston's Emanuel AME Church in a bible study. After sitting with them for approximately one hour, he opened fire on them, murdering nine of the 12. Tywanza Sanders, his great aunt Susie Jackson, Reverend Senator Clementa Pinckney, Reverend Daniel Simmons, Sr., Reverend Sharonda Coleman Singleton, Reverend DePayne Middleton Doctor, Myra Thompson, Ethel Lance, and Cynthia Hurd were murdered. Tywanza's mother, Felicia Sanders, and her 10-year-old granddaughter survived by feigning death. The murderer told Polly Sheppard that he was allowing her to live so she could share what had happened. He hoped his actions would incite a race war. The Charleston Dorchester Mental Health Center (CDMHC) began serving the survivors and the families the night of massacre. The Charleston Police Department (CPD) deployed the CDMHC clinician embedded with the police department to the hotel where families had been gathered. The following day, CDMHC was called in to meet with the FBI and the CPD to plan a family assistance center. The center then established a church assistance center to address the immediate needs of the congregation. The center deployed clinicians to every wake and funeral and most prayer vigils. The center assisted the church in a funeral planning meeting with the nine families. The center opened its doors to the community in the evenings following the shooting for folks who needed a place to talk about their sadness and their shock. The center worked with the children of the church through its vacation bible school. Center staff were present at Mother Emanuel worship services every Sunday after the shooting until December 2015. The center partnered with the National Crime Victims Center at MUSC to provide ongoing grief support groups and eventually establish an empowerment center on the grounds of the church with financial support from the Office of Victims of Crime. The clinical support team provided guidance to the

church and city of Charleston as they planned the first anniversary memorial events. The clinical team also attended the women's ministry and seniors' ministry meetings to reach out to more folks. The powerful lessons learned on this journey have been many. Race had to be addressed in a bold, yet sensitive way. The entire community felt pain; so many layers of victims had to be served. Law enforcement, fire service, coroners, and media sought clinical assistance. Decisions had to be made about which clinicians should serve the church and which should not. The church suffered multiple losses, which had to be acknowledged and addressed. Family dynamics, varied as the family members, had to be navigated by clinicians. Reaching the men in the church remains a challenge. Currently, the clinical team is attending the federal death penalty trial with families. Treatment and support will be provided for at least the next three years.

No. 3
Dealing With Addictions From Policing to the Criminal Justice System
Presenter: Elie G. Aoun, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Recognize the strengths and weaknesses of law enforcement training in working with individuals with SUD; 2) Understand the state of the services offered to incarcerated individuals with SUD and their limitations; 3) Identify the role of mental health professionals in assisting law enforcement officials interacting with individuals with SUD; 4) Describe the interventions available for SUD at each stage of arrest and incarceration and how these interventions actually affect outcomes; and 5) Discuss recommendations for the treatment of SUD in the criminal justice system.

SUMMARY:
Part of Rapid-Fire Talks: Focus on Criminal Justice Collaborations

Special Sessions

Friday, October 20, 2017

Integrating Behavioral Health and Primary Care: Practical Skills for the Consulting Psychiatrist
Director: Anna Ratzliff, M.D., Ph.D.
Faculty: John Kern, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3) Describe the roles for a primary care consulting psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations.

SUMMARY:
Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded $2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health

programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project.

Saturday, October 21, 2017

Conversations on Diversity
Chair: Ranna Parekh, M.D.
Presenters: Helena B. Hansen, M.D., Ph.D., Vabren Watts, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Afford APA members the opportunity to share experiences, history and perspectives about diversity in organized psychiatry; 2) Discuss how health care and patient demographics are impacted by diversity; and 3) Share ideas that will help the APA better serve its MUR constituents, patients and communities.

SUMMARY:
Conversations on Diversity and Health Equity With APA Members was created in 2015 to provide a setting where all APA members could share experiences, histories and perspectives about diversity. Additionally, the program serves to help the APA and the Division of Diversity and Health Equity (DDHE) customize goals and programming. Participant feedback is used to assist the APA/DDHE in better serving its MUR constituents, patients and families. The event is evolving as a platform for members to increase awareness and cultural competence and to facilitate their understanding of diversity as a driver of health care and institutional excellence.

Primary Care Skills for Psychiatrists
Chair: Jeffrey T. Rado
Presenters: Lori Raney, M.D., Lydia Chwastiak, M.D., M.P.H., Jaesu Han, M.D., Alyson Myers, Martha C. Ward, Amy Newhouse

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss lifestyle modifications that are useful; 2) Improve current state of the art knowledge in treating diabetes, hypertension and dyslipidemias; 3) Develop skills in understanding the use of treatment algorithms for prevalent chronic illnesses in the SMI population; 4) Increase comfort in using screening guidelines for early identification of common diseases; and 5) Understand key concepts in prevention and treatment related to obesity, tobacco use and vaccinations.

SUMMARY:
Patients with mental illness, including those with serious mental illness (SMI), experience disproportionately high rates of tobacco use, obesity, hypertension, hyperlipidemia and disturbances in glucose metabolism. This is often partially the result of treatment with psychiatric medications. This population suffers from suboptimal access to quality medical care, lower rates of screening for common medical conditions and suboptimal treatment of known medical disorders such as hypertension, hyperlipidemia and nicotine dependence. Poor exercise habits, sedentary lifestyles and poor dietary choices also contribute to excessive morbidity. As a result, mortality in those with mental illness is significantly increased relative to the general population, and there is evidence that this gap in mortality is growing over the past decades. Because of their unique background as physicians, psychiatrists have a particularly important role in the clinical care, advocacy and teaching related to improving the medical care of their patients. As part of the broader medical neighborhood of specialist and primary care providers, psychiatrists may have a role in the principal care management and care coordination of some of their clients because of the chronicity and severity of their illnesses, similar to other medical specialists (nephrologists caring for patients on dialysis, or oncologists caring for patients with cancer). The APA recently (July, 2015) approved a formal Position Statement calling on psychiatrists to embrace physical health management of chronic conditions in certain circumstances. Ensuring adequate access to training is an essential aspect of this new call to action. There is a growing need to provide educational opportunities to psychiatrists regarding the evaluation and management of the leading cardiovascular risk factors for their clients.

This course provides an in-depth, clinically relevant and timely overview of all the leading cardiovascular risk factors which contribute heavily to the primary cause of death of most persons suffering with SMI, and allows for the profession of psychiatry to begin to manage some of the leading determinants of mortality and morbidity in patient populations frequently encountered in psychiatric settings.

Symposia

Thursday, October 19, 2017

Improving Access and Treatment Engagement Through Integrated Care: Translating National Policy Into Local Practice in the VA

Chair: Andrew S. Pomerantz, M.D.
Presenters: Marsden Hamilton McGuire, M.D., Peter Hauser, M.D., Paul Deci, M.D.
Discussant: Lori Raney, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the complex challenges of developing and overseeing implementation of national policy in a very large health care system; 2) Have familiarity with the components of integrated care that differentiate it from traditional specialty mental health care; 3) Build on the lessons learned at the VA to develop local solutions to overcome common barriers when implementing integrated care programs; and 4) Understand many of the mental health concerns unique to the veteran population.

SUMMARY:

In 2005, the American Psychiatric Association recognized the contribution of integrated care to improving access to mental health services by awarding its gold achievement award to the White River Junction (Vermont) Veteran Affairs (VA) medical center's Primary Mental Health Care program. Soon afterward, the VA recognized the value of this program, and in 2007, all VA medical centers and larger community-based outpatient clinics (CBOCs) were required to begin implementation of this program. In 2011, the VA further supported integrated care by incorporating the program into its newly developed patient-centered medical home, the Patient Aligned Care Team. Although the VA does not rely on the fee for service reimbursement methodology that has slowed the growth of integrated care throughout the rest of health care, implementation of the program has been slow and uneven across the system. Successful implementation in most sites often requires reassigning and retraining staff accustomed to working in traditional mental health clinics. With the rising workload following the recent wars in Iraq and Afghanistan, many facilities struggle to keep up with demand for specialized mental health (MH) care, and leaders are often reluctant to reassign staff from those programs to primary care. At present, most integrated care programs are staffed at about half or less of the recommended levels. Despite these limitations, national evaluation to date has demonstrated the effectiveness of this initiative in improving the likelihood that veterans in need of mental health care will receive it. Veterans and the general public have demanded better access to VA health care, particularly to MH care. In 2016, a bipartisan committee appointed by congress to review VA health care provided support for the quality of VA health care and lauded its integrated care efforts. The commission also stressed the need to improve access. VA leadership identified integrated care as a key strategy to meet this need as well as to meet public demands to improve suicide prevention by enhancing early intervention. As a result, in mid-2016, the VA began a systematic effort to improve implementation. By the end of December 2016, same day access for individuals identified with mental health conditions in VA primary care clinics increased by 10%. In addition to improving access, program evaluation has demonstrated significant improvements in addressing the mental health needs of veterans receiving primary care services in the VA by increasing identification and engagement in evidence-based treatment. In this symposium, VA MH national, regional, and local leaders will review the challenges of operationalizing national policy into tangible clinical practice, as well as review the outcomes of implementation from national, regional, and local perspectives. Factors necessary for success and important lessons learned will be discussed, with particular emphasis on elements applicable across systems.

Friday, October 20, 2017

Mental Health in All Policies: How to Partner With Lawmakers to Improve Mental Health Outcomes in Our Communities
Chair: Ruth Shim, M.D., M.P.H.
Presenters: Marc Manseau, M.D., M.P.H., Joshua Berezin, M.D., M.S., Kevin M. Simon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe the "Health in All Policies" approach and apply it to a mental health framework; 2) Work actively to improve mental health policy at a local government level; 3) Understand how to critically evaluate and screen bills for mental health policy implications; and 4) Interact with local governmental officials (including legislators and staffers) to advance sound mental health policy.

SUMMARY:
The social determinants of mental health (those factors stemming from where we grow, live, work, learn, and age that impact our overall health and well-being) are responsible for many of the disparities and inequities we see in mental health outcomes in our society. These social determinants are shaped by public policies and social norms; therefore, they are modifiable through social and public policy interventions. Significant progress in addressing the social determinants of health has been made by adopting a "Health in All Policies" approach, which incorporates health into decision making across various sectors and policy arenas. This symposium expands the Health in All Policies initiative to consider "Mental Health in All Policies" and equips mental health professionals with the tools to effectively engage and interact with local governments to shape public policies. Few mental health providers feel adequately prepared to interact with legislators and other policy influencers in their local governments, despite the fact that these relationships can prove most effective in directly addressing the social determinants of mental health. Presenters will discuss how to establish relationships with lawmakers, learn techniques for examining bills for mental health policy implications, and will discuss effective ways to influence and educate lawmakers and their staff. Local New Orleans City Council members and mental health activists will provide personal perspectives for building and maintaining positive collaborative relationships with psychiatrists and other mental health professionals.

Outlaws: The Queer Intersection of LGBTQ Rights, Mental Health, and the Law
Chairs: Vivek Datta, M.D., M.P.H., Brian Holoyda, M.D., M.B.A., M.P.H.
Presenters: Brian Holoyda, M.D., M.B.A., M.P.H., Andrew N. Tuck, B.Sc., Vivek Datta, M.D., M.P.H., Ariana Nesbit, M.D., M.B.E., Darlinda Minor, M.D., Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Briefly describe the history of psychiatry as it pertains to LGBTQ rights; 2) Understand what constitutes “conversion therapy,” who practices it, why, and the backlash against it; 3) Discuss the arguments for and against legislation banning “conversion therapy” and the implications for psychiatric practice; 4) Use the minority stress theory to describe how legislated discrimination against trans people can lead to psychiatric morbidity; and 5) Describe the role of the psychiatrist in evaluating the LGBTQ individual seeking political asylum.

SUMMARY:
The history of psychiatry and LGBTQ rights is complex, and the narrative is ongoing. The removal of homosexuality from the *DSM* has undoubtedly advanced the rights of those who identify as lesbian, gay, or bisexual. Adoption rights, same-sex marriage, and the repeal of Don’t Ask Don’t Tell would never have occurred if homosexuality continued to be seen as the developmental end-point of deep-seated psychopathology. Despite this progress, LGBTQ individuals continue to face discrimination. Sexual orientation change efforts (SOCE), or so-called “conversion therapy,” continues to be practiced despite its potential to cause psychiatric harm, leading to legislation against it. Laws banning conversion therapy have been subject to appeals challenging their constitutionality based on claims

they violate the first amendment. We will discuss the arguments for and against this legislation and the potential adverse consequences of such bans on psychiatric practice. Recently, there has also been a wave of legislation focusing on prohibiting trans people from using the bathroom congruent with their gender identity. Using the minority stress theory, we will discuss the psychiatric consequences of enshrining discrimination in legislation. Finally, we will explore how the continuing criminalization of LGBTQ individuals by governments and pathologization by psychiatric associations in other countries may lead these individuals to seek asylum in the United States and the role of the psychiatrist in these cases.

Sobering Thoughts: Challenges and Controversies in Emergency Assessment of Intoxicated Patients With Suicide or Aggression Risk

Chairs: John S. Rozel, M.D., M.S.L., Margaret E. Balfour, M.D., Ph.D.
Presenters: Chinenye Onyemaechi, M.D., Camille Paglia, M.D., J.D., David Pepper, M.D., Tara Pundiak Toohey, M.D., L. Lee Tynes, M.D., Ph.D., David Yankura, M.D.
Discussant: Leslie Zun, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Apply research on the risks of subsequent dangerousness in patients who make threats to harm themselves or others while intoxicated; 2) Understand the clinical and operational questions around timing the evaluation of patients who present intoxicated to psychiatric emergency settings; 3) Evaluate legal and ethical challenges of evaluation while sober or while intoxicated; and 4) Understand the relative merits and limitations of clinical and laboratory evaluation of intoxication and sobriety.

SUMMARY:

Emergency department evaluation of patients who present intoxicated offers significant clinical, ethical, and logistical challenges. This is particularly the case for patients who made suicidal or aggressive statements or acts while intoxicated. Despite the frequency of such presentations, there is little in the literature to provide clear guidance on best practices. The evidence is quite clear, however, that such patients are commonly seen in EDs, are at elevated risk for suicide, are at elevated risk for aggression and agitation, and are prone to extended ED stays. More fundamentally, they pose very challenging clinical questions to emergency psychiatrists. First, when is a patient "sober enough" for a psychiatric evaluation? Many hospitals adhere to "sober by the numbers" or "clinically sober" as prerequisites to psychiatric evaluation. Definitions remain ambiguous for both: is sober by the numbers a BAL under the driving limit or does it need to be nondetectable? How do we assess somebody as being "clinically sober" when a central question will be the quality of their insight and judgment? How do we determine either for a patient using other psychoactive substances such as benzodiazepines or cannabis, medically prescribed or otherwise? Next arises the clinical question: how effective is a sober evaluation of a patient now recanting suicidality with little insight or recollection of what drove their recent suicidal statements in comparison to what they may have revealed during a careful interview while they were still intoxicated? Does it make sense to admit a patient who made significant suicidal or aggressive statements during a rare or isolated alcohol binge, especially if they may not even recall the concerning behaviors? Finally, should we approach the persistently intoxicated patient differently from the sporadically intoxicated patient? This symposium will explore the evidence and clinical best practices for evaluating and managing people presenting for evaluation after threats made while intoxicated. Several case examples will be used, and audience members will be invited to participate in role plays. Guidance will be provided on best practices both for individual psychiatrists as well as for structuring policies and practices for emergency departments.

Saturday, October 21, 2017

Bringing Evidence-Based Practices to the People: The Philadelphia Story

Chair: Lawrence A. Real, M.D.
Presenters: Ronnie M. Rubin, Ph.D., Torrey A. Creed, Ph.D., Daisy R. Lugo, Psy.D., Allison M. Odle, M.S.Ed., M.S., L.P.C., Rinad S. Beidas, Ph.D.
Discussant: Arthur C. Evans, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Explain how the infusion of evidence-based practices (EBPs) into a public behavioral health system is consistent with that system's transformation to a recovery and resilience orientation; 2) Discuss why successful implementation of EBPs in a public behavioral health system necessitates a focus on organizations and programs and not just the training of individual therapists; 3) List three commonly occurring barriers to sustaining EBPs at the provider level and strategies for overcoming them; and 4) Apply lessons learned in Philadelphia to facilitate the implementation of EBPs in their agency or system of care.

SUMMARY:
Over the past several decades, researchers have identified a growing number of evidence-based and innovative practices that are effective in supporting people with behavioral health challenges. Despite rising interest from all stakeholders in providing such evidence-based practices (EBPs) to improve the quality of services and achieve meaningful outcomes for service recipients, research has also shown that only rarely are these empirically supported treatments available in community behavioral health settings. Since 2007, Philadelphia's Department of Behavioral Health has invested significantly in the infusion of EBPs as an essential component of its system transformation, i.e., in using EBPs as a tool to support recovery and resilience outcomes, rooted in the vision that every person should have access to the treatments that are most efficient and effective. This symposium will explore how Philadelphia, via unique partnerships with treatment developers, researchers, and providers, has approached the challenge of identifying, implementing, and sustaining EBPs throughout its system of care. We will begin by describing the creation of the Evidence-Based Practice and Innovation Center to advance system-wide strategies and infrastructure, including increasing knowledge and acceptance of EBPs; integrating them within system policy, fiscal, and oversight functions; and looking at strategies to incentivize EBP delivery. We will trace the development of several key initiatives that, to date, have trained over 600 therapists in over 60 programs, while embedding 12 EBPs in our network of care, within multiple treatment settings and levels of care. In the second presentation, the evolution of the Beck Community Initiative—in place for nearly 10 years—will be discussed in depth, with special emphasis on its transdiagnostic utility and on crucial "lessons learned" about organizational engagement, scale, and sustainability. We will then hear from representatives of one of our provider agencies, whose adaptation of cognitive therapy has spread from one treatment program into a deeply embraced, guiding principle for the entire agency. In the final presentation, the Philadelphia Story will be placed in the broader perspective of EBP efforts elsewhere in the United States, which have utilized alternative approaches such as legislative mandates, and within the growing field of implementation science research. The architect of the EBP initiative, former department commissioner Dr. Arthur C. Evans, will serve as discussant, and he will also be featured, along with Dr. Aaron T. Beck, the "father of cognitive therapy," in an introductory video discussing this unique blending of scientific findings and recovery principles. We are hopeful that this symposium will stimulate the development of a learning community of like-minded partners and systems.

Climate Change: The Ultimate Social Determinant of Health and Mental Health
Chair: David A. Pollack, M.D.
Presenters: Janet L. Lewis, M.D., Carissa Cabán-Alemán, M.D., Joshua C. Morganstein, M.D., Lise Van Susteren, M.D., Elizabeth Haase, M.D., Alex Schrobenhauser-Clonan, M.D., M.Sc.
Discussant: H. Steven Moffic, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Recognize the reality of climate change and its impact on health and mental health; 2) Recognize specific psychiatric conditions that emerge from and/or are affected by climate change and the treatments that are being studied and recommended; 3) Recognize psychological factors, such as denial and hopelessness, that contribute to the refusal to acknowledge this environmental crisis, as well as the failure to act to reverse or mitigate the

local and global risks of climate change; and 4) Recognize the ethical and public health duties for psychiatrists and other mental health professionals to speak out about these threats and to advocate for rational policies to address the threats to health and life posed by climate change.

SUMMARY:
Scientific evidence has unequivocally established the reality of climate change and global warming. The processes of increasing global temperatures, rising ocean levels, and extreme weather events are directly attributable to continued extraction and consumption of carbon-based fuels and the failure to rapidly develop and implement alternative fuels, sustainable alternative energy sources, or meaningful conservation practices. These negative processes are already affecting the environment, plant and animal ecosystems, availability of natural resources, and human behavior at individual, community, national, and international levels. These impacts will only escalate and create catastrophic conditions for most inhabitants of the Earth, especially if no meaningful and timely efforts are effectively implemented to mitigate the processes and trends that have already been observed. Climate change is already impacting human health and well-being, including the emergence of psychiatric syndromes that are directly tied to these environmental changes as well as the complications that are and will be experienced by persons with various preexisting psychiatric disorders. Psychiatrists and other health and mental health professionals must become aware of and adept at recognizing and treating these clinical issues. In addition, there is much evidence that key psychological defenses and thinking errors—in particular denial and hopelessness—operate at individual and societal levels in ways that prevent, frustrate, and even reverse climate change mitigation initiatives. Citing communications science, disaster psychiatry, and other resources, presenters will review and recommend appropriate actions for psychiatrists and other mental health professionals to utilize. We will review ethical and public health obligations that should motivate psychiatric providers to speak out as individual health professionals and as members of health professional organizations to overcome societal denial and inaction and join the global efforts to sustain meaningful life on this planet.

Integrated Pain Management: An Approach to Alleviate Chronic Pain in the Era of the Opioid Epidemic
Chair: Aruna Gottumukkala, M.B.B.S.
Presenters: Paul Sloan, Ph.D., Utpal Ghosh, Sybill Kyle, M.S.N., R.N.
Discussant: Linda L. M. Worley, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand the bidirectional relationship between psychiatric disorders and chronic pain; 2) Define the role of the interdisciplinary team in assessment and management of pain; 3) Outline the principles of the stepped care model and the role of behavioral interventions in pain management; and 4) Learn the importance of opioid risk assessment and review harm reduction strategies.

SUMMARY:
Pain poses a major public health challenge, affecting 40% of the general population (100 million Americans). However, more than 50% of enrolled veterans and almost 60% of veterans returning from the recent war suffer from pain-related symptomatology. Chronic pain poses an economic burden with significant impact on work and quality of life, resulting in severe functional disability (over 10%). Despite increasing awareness of the biopsychosocial aspects of pain and the bidirectional relationship between chronic pain and comorbid psychiatric disorders, accurate attribution of symptoms and diagnosis and choosing an effective treatment have become a clinical challenge. Chronic pain has predominantly been treated in specialty pain clinics for the past several decades, often with opioids, resulting in an epidemic of deaths from opioid overdoses. In response to the epidemic, the Centers for Disease Control and Prevention (CDC) has recently published "Guidelines for Prescribing Opioids for Chronic Pain-United States, 2016," intended for primary care physicians. The U.S. Surgeon General released the first ever report on alcohol, drugs, and health, calling for a cultural shift to end the stigma and emphasizing the need for a

focus on effective treatment and recovery. Effective management of chronic pain needs a combination of strategies within primary care settings, including early interventions to minimize the progression to chronic pain, suffering, and disability and to improve quality of life and functional recovery. In this symposium, we will discuss outcomes of the clinical interventions that our integrated pain evaluation clinic adopted at Michael E. DeBakey VA medical center, which is one of the largest medical centers in the United States. We first review the epidemiology of pain, biopsychosocial factors that contribute to pain, and the neurobiological basis for the bidirectional relationship between pain and psychiatric disorders. We will discuss the unique roles and perspectives of different team members in our interdisciplinary team, as they provide pain assessment and treatment. We will review the elements of the stepped-care model for pain management (SCM-PM) and the evidence that supports nonpharmacological behavioral interventions for pain management. We will then discuss the importance of using tools for opioid risk assessment and the role of office-based buprenorphine, case management, and opioid education and naloxone distribution (OEND) programs as a harm reduction strategy. We will end by discussing the clinical and legal interface between pain management and substance use disorders and how patients can be triaged so that they receive care in the clinical setting most suitable for their needs.

LGBTQ People of Color (POC): How Current Events Reveal Unique Challenges and Treatment Opportunities

Chair: Amir K. Ahuja, M.D.
Presenters: Jose Vito, M.D., Vivek Datta, M.D., M.P.H., Kali D. Cyrus, M.D., M.P.H., Matthew Dominguez, M.D., M.P.H.
Discussant: Kenn Ashley

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the unique issues that LGBTQ ethnic and racial minorities face; 2) Describe how being a double minority can increase stress and lead to negative health outcomes; 3) Identify the issues surrounding substance use in racial and ethnic LGBTQ communities; 4) Employ strategies to better treat LGBTQ racial and ethnic minorities; and 5) Identify the interaction between sexuality and culture and its positive and negative impacts.

SUMMARY:

In this symposium, presented with affiliation from the Association of LGBTQ Psychiatrists (AGLP), the unique issues faced by lesbian, gay, bisexual, and transgender people of color (LGBTQ-POC) will be explored from multiple angles. Current events in the world will be used as a lens to examine these challenges and the resulting psychiatric impact to these communities. Afterward, treatment strategies will be explored in order to best serve this community at an individual and a system-wide level. The first presentation deals with substance use in LGBTQ-POC. These communities have been disproportionately affected by the drug epidemic in the United States. This has resulted in many negative health outcomes, both in terms of physical health and certainly in terms of mental health. This is from a combination of factors. First, substances themselves lead to negative psychiatric outcomes. Second, substance use creates severe social and financial stressors including homelessness and lack of any social support, which greatly exacerbates all psychiatric conditions. Finally, resulting targeting of minorities and mass incarceration in these communities have affected people's ability to get help and have damaged trust with the system. The next topic is about double discrimination. It is widely known that discrimination negatively impacts both the physical and mental health of minority groups. Members of multiple-minority groups, such as LGBTQ-POC, are disproportionately at risk for negative health outcomes due to chronic stress from stigmatization, discrimination, and fear of rejection. Using the minority stress model, which analyzes the complex relationship between external (discrimination/prejudice) and internal (self-doubt/rumination) stressors, we will attempt to understand the lived experiences of LGBTQ-POC in this tense political context and will examine our role as mental health providers in exploring how these threats shape the experience of our multiple-minority patients. The next topic involves the intersection between being LGBTQ and cultural values of racial and ethnic minority groups using the example of the Orlando shooting of 2016, which

shocked the nation as the deadliest mass shooting in U.S. history. It is also noticeable for being an act of terror perpetrated by LGBTQ-POC against other LGBTQ-POC. In this presentation, we will explore the psychological impact of conflicted sexuality as it occurs in LGBTQ-POC, sometimes with tragic consequences. Further, we will discuss the psychological effects of internalized homophobia and latent or repressed homosexuality in LGBTQ-POC. Finally, a treatment approach combining psychodynamic and cognitive-behavioral approaches will be proposed, with the goal of guiding patients toward an integrated sense of self and improving the capacity for the formation of secure attachments. The application of the principles of trauma-informed care to working with LGBTQ-POC will also be considered.

Maternal Substance Abuse and Neonatal Abstinence Syndrome: Multidisciplinary Collaboration to Promote Engagement, Recovery, and Infant Development

Chair: Howard J. Osofsky, M.D., Ph.D.
Presenters: Erich Conrad, M.D., Joshua D. Sparrow, M.D., Robert Maupin, Joy D. Osofsky, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand current information about mental and behavioral health interventions for maternal substance abuse during pregnancy, neonatal abstinence syndrome, and related problems following delivery; 2) Demonstrate knowledge of evidence-informed psychiatric and mental health practices for pregnant women abusing substances and barriers to treatment; 3) Understand the complex factors that affect prenatal substance abuse leading to increased developmental risk and infant mental health; 4) Learn about methods to support the developing parent-child relationship prior to and following birth and the benefit of trauma-informed prenatal and neonatal mental health services and interventions; and 5) Learn about a multidisciplinary program that increases the quality and continuity of mental health services and training of nonmental health professionals to improve maternal and infant well-being.

SUMMARY:

Opioid abuse during pregnancy has been growing in frequency and severity. Recent data demonstrate large increases in newborns born dependent on drugs (neonatal abstinence syndrome), with hospital costs associated with treating them estimated at $1.5 billion annually. These figures do not include costs associated with treating mothers with drug addictions or long-term costs in meeting the developmental, health, and educational needs of infants exposed to substances in utero. They do include burgeoning costs of foster care, child welfare, and judicial involvement. While as many as 20% of women experience new-onset and recurrent major mood, anxiety, and even psychotic disorders prenatally and in the postpartum period, serious mental illness is underrecognized and often not addressed. Perinatal mental health concerns are associated with obstetrical and neonatal complications and can contribute to premature birth, biological risk, increased cesarean delivery, and postpartum depression. These high-risk situations can subsequently contribute to abuse and neglect and resultant child behavioral and emotional problems. Medical and mental health risk factors also adversely influence parent-infant attachment and infant development. A collaborative program of the departments of psychiatry, obstetrics and gynecology, and pediatrics at Louisiana State University Health Sciences Center, with focus on mental health and substance abuse, is addressing the need to improve quality of care to improve outcomes for high-risk mothers and infants. With patient input, senior clinicians from the three departments are developing more comprehensive and integrated services, with continuity of care provided at delivery, during neonatal intensive care, and follow-up infant care. Maternal and infant health specialists—masters-level social workers with expertise in trauma, mental illness, and substance abuse—collaborate with physicians and staff, meet with the mothers when they come for appointments, and follow up between appointments to provide a supportive relationship during pregnancy and after the baby is born. Senior clinicians provide education for physicians, residents from the three specialties, and hospital staff on patient and cultural sensitivity, motivational interviewing, and evidence-informed parent-infant interventions. Early intervention to prevent medical

and behavioral health problems, including those related to substance abuse, has been shown to be cost effective and to benefit society at large. In order to improve care and outcomes, there is a need for increased coordination and collaboration across departments, institutions, and systems; however, there are few integrated and comprehensive programs. Evidence indicates that this innovative program is of much benefit to mothers and infants and that it will reduce short- and long-term costs by increasing access and utilization of mental health support for maternal and infant well-being.

People With Mental Illnesses in the Criminal Justice System: Answering a Cry for Help
Chair: Kenneth Minkoff, M.D.
Presenters: Stephanie Le Melle, M.D., M.S., Jacqueline M. Feldman, M.D.
Discussant: Fred C. Osher, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand the experiences of individuals and families with mental illness and substance use disorders in the criminal justice system; 2) Be familiar with the use of the sequential intercept model to design interventions to prevent and reduce incarceration; 3) Learn and practice specific strategies at each intercept for how to improve outcomes as an individual practitioner; 4) Learn specific strategies for how to make a difference in your own organization, program, or system; and 5) Understand how to create a system impact through participation in the national Stepping Up initiative.

SUMMARY:
Justice involvement of people with mental illness, often with co-occurring substance use disorders, has reached critical levels. Hundreds of thousands of people with serious mental illness are incarcerated, and many more are under community correctional supervision. An APA publication from the Group for the Advancement of Psychiatry (GAP) Committee on Psychiatry and the Community serves as the foundation for this symposium. The symposium begins with a brief context of the problem of justice involvement for individuals with mental illness. The focus of the symposium, however, is not just to describe the problem but, using the results of the GAP publication, to provide specific examples of how participants can take action in their own practices, programs, and local systems, within available resources. The foundation of the GAP report was soliciting letters from Dear Abby's column describing stories of individuals and families with behavioral health conditions who had been incarcerated. The committee received over 3,000 letters. These letters are not only used to engage the listener in the experiences of "real people," they were used by the committee as "case examples" for illustrating innovative practice and program approaches for improving services to prevent or reduce incarceration. In line with the report, this symposium will organize the discussion according to the sequential intercept model, developed by Dr. Mark Munetz, one of the committee members. At each intercept point, there are illustrations for how to respond to the scenarios in the letters, with recommendations for action steps that lead to changes in clinical practice, program policy, and local system collaboration and that can be undertaken by psychiatrists, program leaders, and other practitioners working at any level. After introducing the letters and describing the sequential intercept model, each presenter in the symposium will focus on a particular intercept, using specific examples. The intercepts include provision of proactive and welcoming crisis response to prevent arrest, partnering with law enforcement and court personnel after arrest, collaborating with judges around sentencing and therapeutic justice, partnership between community systems and jail-based services, and partnership with community corrections to provide integrated interventions to address co-occurring disorders and criminogenic risk. Each of these areas will provide an opportunity to involve participants in thinking and talking about what they might be able to change in their own settings. Finally, our discussant will engage participants in thinking about opportunities to influence systems change on the state and national level through describing the Stepping Up initiative. Our discussant will raise further questions and set the stage for active audience engagement on this clinically, politically, and ethically challenging topic.

Telepsychiatry in High-Risk Settings

Chair: Rachel Zinns, M.D.
Presenters: Stephen Ferrando, M.D., Anthony Ng
Discussant: John Santopietro, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Discuss the evidence base for using telepsychiatry to treat high-risk populations; 2) Assess telepsychiatry implementation models with respect to safety measures; and 3) Identify strategies for managing clinical risk in telepsychiatry.

SUMMARY:
Telepsychiatry has been used with increasing frequency to mitigate physician shortage and to improve access to psychiatric treatment. Indeed, the need for telepsychiatry services has been so great that clinical practice has outpaced research on the topic. Moreover, outcome studies on telepsychiatry tend to look at quality measures such as patient satisfaction, wait times, and no-show rates. Few studies measure clinical outcomes, and even fewer do so in high-risk populations. Because of this, psychiatrists are often hesitant to treat psychotic or suicidal patients using telepsychiatry. The purpose of our symposium is to present the audience with both evidence of the effectiveness of telepsychiatry for high-risk populations and a framework for assessing telepsychiatry implementation models across varied clinical settings with respect to safety measures. Both systems-based and interpersonal strategies for minimizing and managing clinical risk through telepsychiatry will be presented. One speaker will discuss outpatient telepsychiatry, including a retrospective study in which all the patients in a state hospital-operated outpatient clinic were treated solely by telepsychiatry by one psychiatrist for a year. Compared to the previous year, when the clinic received traditional in-person treatment by several "covering" psychiatrists, psychiatric hospitalization rates decreased from 23% to 18% and incidence of suicide and violence decreased from 12% to 5%. Furthermore, clinical outcomes from the telepsychiatry clinic were compared to outcomes from other clinics within the same state-hospital system. Compared to the averages from all the clinics in the system, the patients in the telepsychiatry clinic had six percent fewer psychiatric hospitalizations, seven percent fewer psychiatric emergency room visits, eight percent fewer incidents of suicide or violence, and seven percent fewer medical/surgical hospitalizations. Another speaker will present outcomes from a recently opened telepsychiatry inpatient unit (the first in New York State) and strategies for managing risk on inpatient units and psychiatric emergency rooms. A third speaker will discuss telepsychiatry consultation to a large system of medical emergency rooms, where telepsychiatry services have reduced length of ER stay by 50% and restrained transports by 70-90%. A fourth speaker will discuss strategies for employing and training telepsychiatrists to work in high-risk settings, ranging from inpatient units and emergency rooms to outpatient mental health clinics and primary care offices.

Workshops

Thursday, October 19, 2017

Big Goals, Small Steps: The Psychiatrist's Journey to Advocate
Chair: Sarah Y. Vinson, M.D.
Presenters: Ruth Shim, M.D., M.P.H., Kenneth Thompson, M.D., Wesley E. Sowers, M.D., Rupinder Legha

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify various forms of physician advocacy; 2) Discuss the psychiatric physician's role as advocate; 3) Identify potential roadblocks to advocacy efforts; and 4) Collaborate with colleagues to develop personalized, actionable steps for advocacy.

SUMMARY:
As physicians profoundly aware of the biopsychosocial aspects of mental health and illness, psychiatrists have a unique lens for advocacy afforded by their expertise and training. Additionally, they have a natural platform for advocacy afforded by their title. For many, particularly in community psychiatry, professional identity shapes their role as citizens in the larger society. With a new federal administration that has expressed great interest in the reform of the health care system as well as safety net and entitlement programs, many

resources upon which our patients depend are subject to change in ways that could have significant implications for their health and well-being. While the uncertainty of practicing psychiatry in such an environment can be challenging, it may also serve as an inspiration for physician advocacy efforts. Additionally, the threat of clinician burnout from working with broken systems could, perhaps, be mitigated by a psychiatric workforce that uses its voice in efforts to shape those same systems. The undertaking of advocacy, however, can be daunting. In times of great polarization, the risks of being outspoken, particularly against those in power, may be magnified. Some issues are of such complexity that it can be difficult to have any idea where or how to start addressing them. And then there is the scarcity of time: between clinical, administrative, and personal demands, practically, where does advocacy fit? In this workshop, four psychiatric physicians at various stages in their careers will discuss their journeys to advocacy. They will share how they identified their areas of activism; challenges they have faced; how their efforts have been shaped by the different social, political, and academic environments in which they have operated; and their lessons learned. The panelists include Dr. Ken Thompson, medical director of the Pennsylvania Psychiatric Leadership Council and a physician advocate fellow of the Institute of Medicine as a profession at Columbia University; Dr. Ruth Shim, Luke and Grace Kim Professor in Cultural Psychiatry, associate professor, department of psychiatry and behavioral sciences, University of California, Davis; Dr. Rupinder Legha, child and adolescent psychiatry fellow at the University of California, Los Angeles, and former fellow in global mental health at Partners in Health; and Dr. Wes Sowers, clinical professor of psychiatry at the University of Pittsburgh Medical Center and director of the Center for Public Service Psychiatry at Western Psychiatric Institute and Clinic. The panelists' comments will prime the audience for an interactive workshop in which participants will share and explore their own ideas about and methods for advocacy and activism.

Certified Community Behavioral Health Centers (CCBHC): The New CMHC on Steroids!
Chair: Joseph Parks, M.D.
Presenter: Chuck Ingoglia

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand the requirements to become a certified community behavioral health center; 2) Understand the payment methodology for certified behavioral mental health centers; and 3) Understand how certified community behavioral health centers will broaden and enhance the role of psychiatrists.

SUMMARY:
Certified community behavioral health centers (CCBHCs) were created through Section 223 of the Protecting Access to Medicare Act (PAMA), which established a demonstration program based on the Excellence in Mental Health Act. The Excellence in Mental Health Act demonstration program—also known as the Excellence Act or the Section 223 demonstration program—is a two-year, eight-state initiative to expand Americans' access to mental health and addiction care in community-based settings. In December 2016, the Substance Abuse and Mental Health Services Administration announced the selection of the eight participating states: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. The Excellence Act established a federal definition and criteria for CCBHCs. These include 1) integrating both substance abuse and mental health services and behavioral health services with primary care; 2) becoming more data-driven—they are required to collect and report data on 27 different performance indicators, some of which are costs, some utilization measures, some process measures, and some outcome measures; some are behavioral health and some related chronic medical illness; 3) requirement to have a continuous quality improvement plan and process; 4) requirement to have 24-7 crisis response capability, including emergency crisis intervention, 24-hour mobile crisis teams, and crisis stabilization services; 4) requirement to make evening and weekend hours available; 5) requirement to have a medical director; 6) requirement to actually directly provide (or contract with partner organizations to provide) both substance abuse services and mental health services; 7) requirement to provide medication-assisted treatment for addictions; 8)

requirement that their patients get a general health risk assessment and get monitored for metabolic syndrome; and 9) requirement to have a formal system to assess the current competence of any staff providing treatment services. Overall, these requirements provide a substantially higher level of performance than most CMHCs currently. CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care (prospective payment). There is the option of doing a performance bonus payment. CMS has defined 11 performance measures that must be met for any quality bonus payment to occur—the state can add additional quality bonus requirements, and states have wide discretion in how big a quality bonus payment to make. Ultimately, the demonstration program is expected to infuse more than $1.1 billion into community-based services, making it the largest investment in mental health and addiction care in generations. The prospective payment system will remove the current financial disincentives that behavioral health organizations have to increase psychiatric staffing. The requirement to have a medical director and the additional service requirements will significantly broaden and enhance the role of psychiatry.

Developing a National Mental Health Registry
Chairs: Saul Levin, M.D., M.P.A., Grayson Norquist, M.D., M.S.P.H.
Presenters: Diana E. Clarke, Ph.D., M.Sc., Debbie Gibson, M.Sc., Grayson Norquist, M.D., M.S.P.H., Alvaro Camacho, M.D., M.P.H.
Discussant: Anita Everett, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) To help attendees understand the importance of the APA National Mental Health Registry; 2) To help attendees understand the importance of the inclusion of the clinician and patient portals/dashboards as part of the APA Registry; 3) To help attendees understand the key features and functionalities of the clinician and patient portals/dashboards; and 4) To help attendees understand how the clinician and patient portals can inform improvements in clinical care.

SUMMARY:

With recent changes to health care delivery, the opportunity to use patient registries to improve quality of care and patient outcomes has never been greater. Registries seek to achieve several important goals, including supporting quality reporting by physicians and other health care providers; improving the quality of care for patients; and helping provide research data needed to develop new quality measures as well as to improve diagnostics and therapeutics. For psychiatrists, specifically, a patient registry represents a simplified solution for meeting quality-reporting standards while avoiding payment penalties for failure to report on use of quality measures. It also will facilitate psychiatrists meeting Maintenance of Certification (MOC) Part IV reporting requirements. Given these benefits and the need to adapt to the rapidly shifting landscape of care delivery into one based on quality reporting, the American Psychiatric Association (APA) has developed a national mental health registry (PsychPRO) that is a Centers for Medicare and Medicaid Services (CMS) Qualified Clinical Data Registry (QCDR). PsychPRO will aid participating psychiatrists, and other behavioral health providers, in meeting MIPS reporting requirements. PsychPRO has improved upon earlier registries developed by other medical specialties by incorporating clinician and patient portals/dashboards. These portals are inter-operable and allow for the electronic (e-)assignment of patient reported outcome measures (PROMs) such as the *DSM-5* Review of Mental Systems, PHQ-9, AUDIT-C, neurocognitive battery, and the WHO-DAS 2.0 by the psychiatrist or his/her authorized administrative staff, the e-completion of the PROMs by the patient or their proxies, and the use of the e-scored and e-transmitted results by the clinician in his/her clinical evaluation of the patient. The inclusion of these portals and the PROMs is a basic but necessary step toward engaging patients in their evaluation and car e. Additionally, these PROMs can aid the psychiatrist in meeting quality reporting requirements and avoiding payment penalties by augmenting data derived from the psychiatrist's electronic medical records (EMR). This workshop will show how PsychPRO improved upon earlier registries developed by other specialties, discuss its security features, explain its benefits to clinicians and their patients, demonstrate its features and

functionalities, and lastly discuss how it can inform overall improvements in clinical care. By the end of the workshop, attendees will be able to understand the benefits of the APA Registry and determine if they would like to participate in this important initiative.

Evaluating Psychiatric Smartphone Apps: Applying the APA App Evaluation Model

Chairs: John Torous, M.D., Steven Chan, M.D., M.B.A.
Presenters: Jung W. Kim, M.D., Shih Yee-Marie Tan Gipson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Know the four factors in the APA app evaluation model; 2) List at least three risk and three benefits of app use; and 3) Apply the APA app evaluation model to apps on the commercial app store.

SUMMARY:

Despite tremendous interest, there remain many important barriers and concerns toward using mobile technology like smartphone apps and fitness tracker data in clinical care. In this workshop, participants will learn to evaluate smartphone apps using the APA smartphone app evaluation model through hands-on, interactive real-life cases/apps. Participants will be active learners in directly applying the APA smartphone app evaluation to apps they may already be using, or are interested in, and learn how to make an informed choice whether that app is appropriate for use with patients or not. Of note, no experience with technology or apps is necessary, and those not interested in using apps will still learn how to discuss, approach, and frame app use when patients may ask about such.

Integrating Substance Use Disorder Services Into Complex Physical Health and Mental Health Systems

Chair: Kenneth Minkoff, M.D.
Presenters: Christie Cline, M.D., M.B.A., Aniedi Udofa, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of a system-wide approach to the integration of SUD into MH and PH services; 2) Identify the six evidence-based principles of successful integrated treatment and their associated interventions and practices; 3) Use continuous quality improvement to implement integrated practices and services in any setting; 4) Be familiar with real-world implementation of SUD integration in a regional provider system in Louisiana; and 5) Identify specific next steps for improving integration of SUD services in one's own setting or organization.

SUMMARY:

It is well recognized that people seeking physical health (PH) and behavioral health (BH) services have complex needs, including co-occurring mental health (MH), trauma, substance use (SUD), PH, cognitive, and other human service challenges, and that providing integrated services to meet those needs is a priority for successful achievement of the triple aim. In recent years, the focus of integration efforts has increasingly been on PH-BH integration, leading to the impression that the "BH" (MH and SUD) integration has been accomplished. This is, however, far from the case, and the recent opioid epidemic has made the need for attention to this issue even more pressing. This workshop addresses this issue head on, so that participants can leave with concrete ideas and next steps about how to improve integration of SUD services into MH and PH services in their own settings. The workshop begins with a review of the need to prioritize people with co-occurring conditions in all settings and specific principles and EBP interventions for integrating SUD into MH and/or PH in any setting for any population. Specific practices to be addressed include welcoming and engagement, screening and identification, integrated teamwork, assessment and service planning, stage-matched treatment, medication-assisted treatment (buprenorphine, naltrexone), individual and group skill building, and peer recovery support. Examples will be provided about areas of challenge and progress in multiple state and local systems across the U.S. The next presentation will focus on how to engage an entire organization in making progress in integrating SUD services, so integration belongs to all staff and all programs. This begins with a framework of customer-oriented continuous quality improvement (CQI), recognizing

that individuals using substances, particularly those who are not immediately wanting to change, are at high risk of high cost and poor outcome and are therefore a priority to welcome and engage in ANY setting with ANY team. This presentation will illustrate the basic steps, tools, and strategies for inspiring and empowering all levels of an organization to make measurable progress in implementing the integrated practices described. The final presentation will illustrate successful progress in integration of MH and SUD in a regional system in Louisiana. Capital Area Human Services (CAHS), a community-based behavioral health treatment organization, is a leader in the Baton Rouge region, implementing innovative strategies for integrating MH, SUD, and PH services agency-wide. CAHS's successes and best practices will be shared with participants, including universal MH and SUD screening of clients accessing outpatient and residential treatment services and effective identification and engagement of individuals with MH and SUD problems through colocation of substance-trained MH professionals in a local FQHC, parish prison, and prenatal clinic.

Microaggressions, Macroeffects: The Front Lines of the Fight Against Stigma
Chair: Madeline B. Teisberg, D.O., M.S.
Presenters: Megan Elizabeth Baker, M.D., Kimberly Gordon, M.D., Patcho N. Santiago, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand microaggressions, implicit bias, and examples of how they affect patient care; 2) Identify the ways in which microaggressions and implicit bias affect both patients and clinicians; and 3) Engage colleagues and patients with new communication skills after practicing exercises teaching techniques that can be incorporated into a clinician's daily routine.

SUMMARY:
Implicit bias and microaggressions affect all levels of medical care. Far from being subtle or small, an emerging literature suggests these phenomena can have big effects on access to care, care effectiveness, and even stigma. Manifestations can range widely, from assumptions about patient socioeconomic status or personality to recommending a different treatment depending on a patient's ethnicity, gender, or disability status. A recent study found that a black, working-class man would have to call 16 times as many therapists before finding care. This can erode patient trust, undermine therapeutic alliances, discourage patients from seeking care, and potentially worsen outcomes. Providers also experience these biases and microaggressions, which undermine their ability to provide excellent care and may contribute to burnout and worsen provider well-being. Indeed, many academic institutions struggle to foster diversity at the highest levels of their organizations. An understanding of these factors is essential to increasing access to care, providing quality care, and fostering well-being among providers and patients. The workshop will involve participants engaging with microaggressions that occur on a daily basis in our offices, clinics and hallways. A panel of facilitators will lead a group discussion regarding identified types and categories of microaggressions, common reactions and how they might affect our own interactions. Participants will be provided with resources to examine their own implicit biases and we will conclude with strategies; both individual and systemic, to combat microaggressions and implicit biases in our daily practice. Questions and discussion will be encouraged.

Primary Care Clinician Retention as an Opportunity for Consulting Psychiatrists: Safety Net Clinics, Experiences of New Hires, and Collaborative Care
Chair: John H. Wells II, M.D.
Presenters: Stephanie Tokarz, M.P.H., Jason Poyadou, Stephanie Losq

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) List the various types of primary care providers, with their clinical roles and styles; 2) Understand the personnel challenges particular to safety net primary care clinics with a focus on retention; 3) Appreciate the pressures facing new hire clinicians in primary care settings, which can lead to premature burnout or substandard practice; 4) Outline the role a psychiatrist collaborating with a primary care clinic can play in retention and job satisfaction; and 5) Initiate and guide a fruitful

working relationship with a consulting provider as part of a collaborative behavioral health team.

SUMMARY:

As part of the Gulf Region Health Outreach Program's Mental and Behavioral Capacity Project-Louisiana, psychiatrists and other behavioral health specialists from the department of psychiatry at Louisiana State University Health Sciences Center (LSUHSC) in New Orleans have been collaborating for four years with safety net primary care clinics in both urban and rural settings to improve access to mental health care. A critical challenge to these safety net primary care clinics is clinician retention. The clinics may be located far from population centers or in undesirable urban areas where it is difficult to recruit clinical staff. The safety net patient population tends to create a demanding panel for primary care clinicians, exhibiting many comorbidities such as substance use as well as a tendency toward advanced illness presentations due to community stigma or lack of access. New hires may be freshly minted family medicine physicians, nurse practitioners, or physician assistants without a depth of experience preparatory for the level of acuity present. Additionally, as burnout and staff turnover are common, the new hire may be accepting a panel comprised of patients whose longitudinal treatment plans and attendant expectations for ongoing care began to founder under treatment by a well-intentioned but overwhelmed outgoing clinician. This workshop is designed as a panel discussion with input from a family medicine physician and a physician assistant from an urban and a rural primary care clinic serviced by LSUHSC's collaborative care team; also present will be a psychiatrist and research associate from the team. We will begin with an overview of the roles of various primary care providers as well as the challenges of retention of staff in primary care. Next, we will discuss our program with views from the psychiatrist consultant as well as the primary care providers themselves, with specific examples from our team experiences such as the inheritance of a panel with a preponderance of chronic use opioid and/or benzodiazepine patients. This will include an overview of how technology plays a role in facilitating communication within collaborative relationships and engendering trust. Finally, we will discuss and field ideas about how a working relationship can be developed in a way that strengthens the ability of both the behavioral health team and the primary care providers to achieve their patient care goals.

Protecting Youth From Online Dangers: Clinical Perspectives and Approaches to the Rise of Social Media and Online Risk Taking

Chairs: Swathi Krishna, M.D., Caitlin R. Costello, M.D.
Presenters: Gabrielle L. Shapiro, Paul Elizondo III, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the widespread popularity and rapidly expanding domain of online activity precipitously influencing a vulnerable underage patient population and impacting their mental health; 2) Provide specific data and examples regarding the increased online activity of teens and examples of the increased risks associated with these activities; 3) Identify and discuss the legality of online activity by teenagers and underage youth—when and how does the law protect them and when does it not?; 4) Highlight and discuss media reports of psychiatric outcomes of youth affected by their online behavior and facilitate discussion on how their activity showed “red flags”—examples include sexting and suicide after cyberbullying; and 5) Provide clinical considerations and approaches to identify high-risk online activity within the underage patient population and how to provide education about monitoring youth online activity.

SUMMARY:

In recent years, adolescents have become increasingly invested in social media and online activities. The rapid adoption of social media outlets such as Facebook, Instagram, Snapchat, and Twitter by underage users have exposed a vulnerable population to a variety of legal, personal, social, and mental health consequences. According to recent research, 92% of teens report daily online activity. Twenty-four percent of these individuals report that they are online "almost constantly," usually using more than one social networking site and sharing copious personal information, including full names, ages, personal photographs, home addresses, school

locations, and social calendars. Communicating and sharing personal information online exposes adolescents to many risks, including cyberbullying, legal consequences from sexting, exposure to online predators, and exposing information to unintended audiences, which could impact their plans for the future. Furthermore, the increase in online activity and online bullying has become a looming safety concern in this population. Negative online exposure can have detrimental effects on the physical and mental health of teenagers, causing depression, anxiety, increased suicidal thoughts, and even reports of completed teen suicide in some cases. This workshop will highlight the vulnerabilities of this at-risk population of underage online users and help identify "warning signs" that may signify that patients need intervention and support. Increases in online activity and social media use also have widespread legal ramifications in the adolescent population that teens, their families, and providers may be unaware of. Although adolescents under the age of 18 are neither recognized in the law as adults nor understood in psychiatry to have the fully developed capacity of adults, they easily enter into online contracts to be able to use social media. In our workshop, we will highlight the legal protections, or lack thereof, of underage online activity. This is an area of ongoing legal debate and has been the subject of several recent court cases that will be highlighted and discussed by our workshop presenters. With insufficient legal protection for adolescents posting online, protecting teens from the risks of immature online decision making often falls to outside adults. Mental health providers have a unique perspective into activities of their underage patients and may be able to provide them with education and warnings about the dangers of online activity. Our goal is to provide insight and information that can be used to engage teen patients in discussions about protecting themselves from the consequences of risky online behavior and provide information to assist mental health providers on how to approach these sensitive topics with their patients and their families.

Psychiatrists as Allies: Navigating Power and Privilege in Psychiatry

Chair: Michaela Beder, M.D.

Presenters: Carissa Cabán-Alemán, M.D., Neal Goldenberg, M.D., M.P.H., Kimberly Gordon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define privilege, oppression, and racism; 2) Develop a self-awareness of our own privilege and/or oppression to better understand how we may impact others; 3) Understand how racial and power dynamics intersect in complicated ways and can affect the quality of the psychiatric services our agencies provide; 4) Identify anti-racist and anti-oppressive strategies that psychiatrists in leadership roles (e.g., medical directors) can implement into service provision; and 5) Incorporate the above concepts to become allies to diverse groups of clients and coworkers.

SUMMARY:

Oppression is woven into the structure and fabric of our society. The evidence is everywhere: murders of black people by police, calls to discriminate against religious groups and those with mental disorders, the exploitation of indigenous lands, increasing wealth inequality, and even misogynist and xenophobic language used by prominent politicians, not to mention countless mental health-related disparities among racial and sexual minority and underrepresented groups that suggest these populations have worse prognoses. For every gain on the side of justice, there is pushback. These injustices are not new—they can be considered historical traumas, which have accumulated from one generation to the next. They impact health, both physical and mental, at the individual and population levels. They are among the forces that contribute to burnout and compassion fatigue among so many in the health professions. In addition to the dramatic consequences of these traumas that we see every day in the media, subtle and perhaps more insidious forces of racism and oppression are incorporated into most North American institutions, including our own community mental health organizations. Interestingly, minority and underrepresented psychiatrists may self-select to work in underserved community clinics and even there find discrimination from their peers and patients due to the subtle microaggressions of an oppressive health system. Oppression, such as racism, impacts both physicians and patients alike. Research shows that there are

racial and ethnic disparities in prescribing practices, diagnosis, and even adherence to evidence-based guidelines. Many well-meaning providers coming from a privileged position may have difficulty recognizing how their comments, recommendations, body language, and policies might be oppressive. This workshop will examine how mental health clinicians, including medical directors and leaders in our field, can improve the agencies and institutions we work for by beginning to shed light on our own institutionalized racism and bringing anti-racist, anti-oppressive practices into our agencies and clinical work. This highly interactive workshop will include audience exercises to define power and privilege, explore how these concepts intersect in our daily work, and provide practical and concrete examples of ways in which we, as mental health clinicians, can become allies with those who are oppressed.

Friday, October 20, 2017

Addressing the Problem of Access to Psychiatric Services
Chairs: Joseph Parks, M.D., Patrick S. Runnels

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Know the extent of the problem patients have accessing psychiatric services; 2) Understand the impact on quality care and patient satisfaction due to current obstacles impacting psychiatric services; and 3) Learn recommended changes to improve access to psychiatric services.

SUMMARY:
This report's content includes an environmental scan, summary problem statement, recommendations based on research and experience in the field, and a set of actionable next steps for stakeholders with the capacity to implement these changes in a host of settings such as the Center for Medicaid and Medicare Services (CMS) and SAMHSA; professional trade organizations for psychiatrists, nurse practitioners, physician assistants, and pharmacists; health care provider organizations; advocacy organizations; and consumer organizations. The report is a practical document designed to highlight key problem areas, distinguish the root causes and effects, identify risks with current trends, find specific innovative solutions already implemented in pockets around the country, and list actionable recommendations for implementation.

Buprenorphine Update and Evolving Standards of Care
Chair: John A. Renner, M.D.
Presenters: Petros Levounis, M.D., M.A., Andrew J. Saxon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe treatment protocols used by psychiatrists around the country who are treating opioid use disorder with buprenorphine; 2) Discuss cutting-edge research related to use of buprenorphine for treating opioid use disorder; and 3) Describe appropriate patient selection for the newly approved buprenorphine implants for treating opioid use disorder.

SUMMARY:
This workshop is intended for psychiatrists who have a waiver to treat opioid use disorder in an office-based setting. It will augment waiver training through case presentations and discussion of treatment challenges with expert faculty. Topics addressed will include patient engagement and monitoring, minimizing diversion, and management of acute and chronic pain. Participants will also be encouraged to share their experiences with reimbursement policies that impede appropriate treatment.

Community Resilience and Psychiatry's Role Following Disaster
Chair: Glenda L. Wrenn, M.D., M.S.H.P.
Presenters: Bowen Chung, M.D., M.S.H.S., Kenneth Brooks Wells, M.D., M.P.H., Ben Springgate, M.D., M.P.H., Ashley Wennerstrom, M.D., Sheila Savannah

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify and improve mental health disparities in the community; 2) Demonstrate and apply new skills that will be useful in public psychiatry settings; 3) Examine how the current health care system affects patient care; 4) Describe

how to transform systems of care; and 5) Recognize how to bring new innovations into a variety of treatments to improve patient care.

SUMMARY:

In the wake of 2005's Hurricane Katrina, Louisiana and, in particular, the New Orleans are have suffered multiple other devastating natural disasters, which have crippled the region and required massive efforts to rebuild. But despite these traumas, the communities of New Orleans and the surrounding areas have demonstrated enormous resilience in the face of adversity. How have these communities bounced back so quickly and what role did psychiatrists play in the recovery? This workshop will focus on Louisiana and New Orleans in the decade following Katrina, including subsequent disasters that have plagued the region in recent years, highlighting the work of recovery and its foundation in community-driven change. Participants will explore how they can contribute to the post-disaster well-being of their communities and can work to strengthen local partnerships necessary to preserve the mental health of their communities following a large-scale disaster like Hurricane Katrina.

Creating Your Voice: A Guide to Publishing in *Psychiatric Services* and the *Community Mental Health Journal*

Chairs: Lisa Dixon, M.D., Jacqueline M. Feldman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the different types of *Psychiatric Services* submissions and their requirements and understand the types of submission sought by the <Community Mental Health Journal<; 2) Be able to match different types of article ideas to the appropriate submission category; and 3) Have greater knowledge and skills in creating publishable articles.

SUMMARY:

Writing for professional journals and other outlets can increase your professional impact and reputation. Clinicians who adopt a scholarly and empirical approach and who are astute observers can publish successfully. Research articles have one set of fairly standard requirements. However, many journals, including *Psychiatric Services* and the *Community Mental Health Journal* (*CMHJ*), publish papers with different demands and review criteria. For example, *Psychiatric Services* also publishes columns in a wide variety of areas, from financing and policy issues to integrated care to research and services partnerships. Frontline reports showcase innovative new programs. Understanding the criteria and how to adapt and present your ideas within different formats will increase your success in publishing. In this workshop, the editor and members of the editorial board of *Psychiatric Services*, and the editor of the *CMHJ* will present the parameters of the different types of articles published in the respective journals. In *Psychiatric Services*, regular articles and brief reports present the results of original research. In general, regular articles should not exceed 3,000 words, excluding abstract, references, and tables and figures. Brief reports should be a maximum 1,800 words (excluding abstract, references, and table), plus no more than 15 references and one table or figure. If you do not conduct research, other types of submissions may be appropriate. Provocative commentaries of 750 words maximum are invited for Taking Issue. Authors may also submit commentaries of 1,200 to 1,600 words and no more than 15 references for the Open Forum section. *Psychiatric Services* columns should not exceed 2,500 total words, including text, no more than 15 references, and an abstract of no more than 100 words. The *CMHJ* does not have specific columns, but often publishes themed issues related to public and community psychiatry, and is working to enhance submissions from international authors. The workshop will review several examples of the evolution and review process of different article types. The workshop will then allow small group discussion of participants' publication ideas. The workshop will teach attendees how to determine what is the best fit for their publication idea and what steps are needed to publish successfully. Workshop attendees will have the opportunity to meet members of the *Psychiatric Services* editorial board, and with the editor of the *CMHJ*.

Cultivating Physician Advocacy: Opportunities and Challenges in Training and Beyond

Chairs: Colin D. Buzza, M.D., M.P.H., M.Sc., Mary C. Vance, M.D.
Presenters: Jessica S. Bayner, M.D., Rebecca Radue, M.D., Rachel Talley, M.D., Onyinye Ugorji, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify the importance of cultivating physician advocacy to promote accessible and effective mental health care for all patients; 2) Discuss the limited and variable exposure to advocacy methods and opportunities within psychiatric training; 3) Describe at least three avenues for pursuing and strengthening advocacy within psychiatric training and beyond; 4) Discuss the benefits and challenges of different avenues to pursuing and strengthening advocacy; and 5) Identify possible methods to cultivate physician advocacy while in training and after residency.

SUMMARY:
Physician advocacy is a powerful and essential factor in addressing structural challenges to accessible and quality mental health care. This has been recognized under several ACGME competency domains and is increasingly acknowledged within the rubric of structural competency. However, effective advocacy may demand responses outside the typical toolkit of a psychiatrist, and exposure to advocacy methods and opportunities within psychiatric training is variable and often limited. In this workshop, we will explore ways to cultivate and strengthen advocacy within psychiatric training and beyond. Our speakers are APA public psychiatry fellows from across the country with a wide range of prior advocacy experiences and training. Building on a reflective exercise with the audience, we will share examples to highlight the variability in advocacy exposure within training, including their successes and challenges. We will then present an outline for engaging in physician advocacy at various levels, from individual to population. We will utilize small groups to evaluate potential opportunities and challenges in promoting advocacy at several of these levels. Finally, we will engage in a large-group discussion to highlight common themes and help audience members consider strategies that can help them cultivate and promote advocacy at their home institutions.

Give It Your Best Shot: Facilitating Use of Antipsychotic Long-Acting Injections
Chair: Raymond C. Love, Pharm.D.
Presenter: Megan J. Ehret, Pharm.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Recognize important difference among antipsychotic long-acting injections (LAIs); 2) Address common clinical situations that arise during the use of LAIs; 3) Educate patients regarding the use of LAIs; 4) Select appropriate patients to receive LAIs; and 5) Discuss strategies to overcome common barriers to the use of LAIs.

SUMMARY:
The U.S. lags behind many other countries in the use of antipsychotic long-acting injections (LAIs). While evidence supports LAI use, the process of approaching patients and selecting candidates for LAIs may not be straightforward. LAIs may be useful to assist in adherence, but patients must still keep appointments or alternatives such as home visits may be necessary to ensure administration. Compared to the first-generation depot antipsychotics—fluphenazine and haloperidol—the use of second-generation antipsychotics (SGAs) can be complicated. Eight formulations of LAIs are now available in the U.S. Some require an IM loading dose strategy, while others require overlap with oral dosage regimens. Dosage selection and titration may or may not be based on oral dose of the drug and may require oral supplementation or extra IM doses. Frequency of administration for various products ranges from every two weeks to every three months for one formulation of paliperidone palmitate. Specific products may require special needles, storage, or administration techniques or be limited to specific administration sites. The olanzapine LAI requires registration in a special program due to the potential of postinjection delirium/sedation syndrome (PDSS). The SGA LAIs can be quite expensive, with a single injection costing more than $8,000 and many costing $2,000-3,000 per month. This may lead pharmacy benefit managers or governmental payers to place formulary restrictions

or use prior authorization processes. Many manufacturers offer patient assistance programs, but these require additional effort on the part of the prescriber. Risperidone appears on a federal list of hazardous drugs. The preparation of its LAI may require use of facemasks, gloves, and other personal protective equipment according to pending regulatory action. All injections require appropriate space for administration and trained clinical staff. This session will use cases and audience input to explore specific challenges encountered when employing LAIs. These may include issues in patient selection, supplemental dosing during initiation and switching LAIs in the event of toxicity or lack of efficacy. Newer strategies for addressing the administrative challenges of LAI use include collaborating with clinic or community pharmacies, some of which cater to patients with behavioral health disorders. Pharmacists in many states can now administer LAIs through various provisions in state laws such as collaborative drug therapy management or expanded medication administration laws. These pharmacies can secure and store these expensive agents, deal with reimbursement issues, administer the LAI, monitor the patient, report back to the prescriber, and reschedule patients for missed doses while offering expanded hours of access and close proximity.

How Many Lawyers Does It Take to Change a Mental Health System? Reflections on Medical-Legal Partnerships in Behavioral Health Settings
Chairs: Ruth Shim, M.D., M.P.H., Mallory Curran, J.D.
Presenters: Jay Chaudhary, J.D., Mallory Curran, J.D., Gregory M. Singleton, M.D.
Discussant: Ruth Shim, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify the key characteristics of medical-legal partnerships (MLPs) in addressing the social determinants of mental health; 2) Consider the role of MLPs in improving mental health outcomes on individual patient, clinical, and population levels; and 3) Develop an action plan to start an MLP in your own clinical setting.

SUMMARY:
The social determinants of mental health are responsible for many of the mental health inequities and poor outcomes for people with mental illnesses. With increasing recognition of the role of the social determinants of mental health, an urgent question has come to the fore: What can we do about them? One answer has come from an unexpected source: patient-centered lawyers partnering with psychiatrists and other behavioral health professionals. Medical-legal partnership (MLP), which integrates lawyers into the health care team, is an innovative model that has had a significant impact in a variety of medical specialties—and is increasingly expanding into behavioral health settings. This creative solution to addressing the social determinants of mental health involves behavioral health professionals partnering with civil legal services lawyers to address the social factors that contribute to poor mental health outcomes. Successful examples include fighting illegal evictions, enforcing disability anti-discrimination laws, and ensuring appropriate special education and other school-based services for students with mental health problems. This workshop will discuss the benefits, challenges, and opportunities of MLPs, including the impact of MLP interventions at the individual, clinical, and population levels. Psychiatrists and lawyers affiliated with successful MLP models in Indiana, New York, and Ohio will present case examples on how MLPs have benefited patients, transformed clinical practice, and provided a pathway to effect policy change. Presenters will also discuss concrete ways that participants can develop MLPs in their own behavioral health settings in order to improve mental health outcomes of their own patient populations.

Implementing an Opioid Overdose Prevention Program for Homeless and Formerly Homeless Individuals
Chair: Glen P. Davis, M.D.
Presenters: Anthony Carino, M.D., Charlotte Austin, B.A., Caitlyn Braschi, B.A., Lily Ostrer, B.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand the public health significance of opioid overdose among homeless populations; 2) Understand the physiology of opioid overdose and the pharmacology of naloxone as an

overdose reversal intervention; 3) Understand evidence supporting brief training and distribution of naloxone as an effective overdose prevention strategy; and 4) Identify resources and potential challenges involved in developing an opioid overdose prevention program for homeless individuals.

SUMMARY:
Opioid overdose is a leading cause of accidental death in the United States, surpassing death by motor vehicle accidents. In 2015, over 33,000 deaths were attributable to prescriptions opioids or heroin, and from 1999 to 2016, the number of deaths involving opioids has more than tripled. Mortality from opioid overdose occurs primarily through respiratory depression, eventually leading to hypoxia, coma, and death. Naloxone hydrochloride, a pure opioid antagonist, is the treatment of choice for suspected overdose, and the intranasal formulation has been shown to be effective in reversing opioid overdoses with a favorable safety profile. Homeless individuals are at significant risk for unintentional death by opioid overdose. Among homeless adults, drug overdose is the leading cause of death, accounting for one-third of deaths among homeless adults under 45 years old. Despite the prevalence of opioid use disorders among homeless populations, there are limited guidelines available on the development and implementation of opioid overdose response initiatives for programs serving homeless individuals. Furthermore, the contingencies of homelessness pose obstacles for providing homeless individuals with education on opioid overdose recognition and access to naloxone overdose prevention kits. This workshop will describe the public health significance of the opioid overdose epidemic in the United States, particularly with regard to homeless and other marginalized populations. We will review the physiology of opioid overdose and the pharmacology of naloxone as an opioid overdose antidote. Presenters will describe the process of training program staff and service recipients on opioid overdose recognition and response with intranasal naloxone. The workshop will describe an agency initiative to implement an opioid overdose prevention program involving training and distribution of naloxone across 25 social services programs serving homeless and formerly homeless individuals in New York City. A collaboration with medical students as partners to implement this initiative will also be described. Since July 2015, the program has provided training on opioid overdose recognition and intranasal naloxone kits to over 1,000 homeless or formerly homeless individuals and program staff who serve them, resulting in 24 reported opioid overdose reversals in the community. Through interactive discussion, workshop presenters and participants will explore challenges involved in opioid overdose program implementation for homeless individuals and strategies to optimize access to this lifesaving intervention. Discussion will also incorporate broader overdose prevention strategies such as community education, medication-assisted therapy for opioid use disorders, and clinical leadership approaches for program implementation.

It Takes a Village: Providing Biopsychosocially Informed Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD) in the Public Sector
Chair: Margaret Chaplin, M.D.
Presenters: Vania Modesto-Lowe, M.D., M.P.H., Tanya Banas, L.P.C., William McNichols, Suzanne Waters

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand how to responsibly prescribe buprenorphine and naltrexone in an outpatient community mental health setting; 2) Be competent to initiate treatment with methadone in a state hospital setting; 3) Understand the importance and implementation of coordinated care for patients with OUD between public mental health settings (methadone clinics, state hospital, residential treatment programs, etc.); 4) Appreciate the role of outpatient psychosocial programs for OUD across the IOP and outpatient level of care; and 5) Understand the importance and need for increased access to MAT in the public sector.

SUMMARY:
Opioid use disorder (OUD) remains a widespread issue associated with significant morbidity and mortality. The most recent CDC data show over 28,000 deaths from opioid overdose between 2010 and 2014. One of the major proposed remedies is to

increase access to treatment. OUD cuts across all sociodemographic lines, but quality treatment, including buprenorphine, is not always available, especially to those without private insurance or the ability to self-pay. There are several proposed explanations for this disparity. Most salient perhaps is financial. As of 2011, most buprenorphine prescribers did not accept Medicare and/or charged substantial fees. In addition, there are professional barriers that create biases against MAT. Physicians may not feel confident in their ability to prescribe. Despite these perceptions, state hospitals and community mental health centers are ideal locations to provide MAT due to the built-in capacity to provide biopsychosocial care. Enhancing physician comfort level with prescribing has been suggested as a means to increase prescribing. This workshop will address the knowledge and confidence gaps by providing examples of the provision of all three FDA medications for OUD in public sector treatment settings that address the biological (medication induction and maintenance), psychological (IOP, 12-step facilitation, relapse prevention, and motivational interviewing, for example), and sociological (coordination of care, integration into the recovery community) aspects of treatment.

Mental Health Treatment in Correctional Settings
Chair: Li-Wen G. Lee, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Develop an understanding of historical trends in the incarceration of individuals with mental illness; 2) Learn about standards of care in correctional settings and a state model of delivering services; and 3) Participate in a discussion about the critical role of psychiatrists, both in correctional settings, and in the care of individuals at risk of incarceration and/or returning to the community from incarceration.

SUMMARY:
The statistics are stark. With 2.2 million people held in federal and state prisons and county jails, the United States has the largest incarcerated population in the world. Superimposed on this figure is data showing that 44 to 75% of inmates, depending on correctional setting and gender, suffer from a mental health problem. Increasing recognition of the scale and scope has led to increasing attention to this population. This workshop will offer an overview of the complex needs of incarcerated individuals, followed by a presentation of the model of service provided in New York State. Challenges remain, and these challenges are not limited to treatment provided behind bars, but also in the areas of community reentry and mental health care prior to incarceration.

Prescribing and Treating Patients With Controlled Substances: Risk Management Considerations
Chairs: Kristen M. Lambert, J.D., M.S.W., Moira Wertheimer, J.D., B.S.N.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Increase awareness of federal and state prescribing regulations and drug diversion programs; 2) Examine the role that prescription drug monitoring programs play when prescribing and identify risk reduction strategies; 3) Explore the role of telemedicine when prescribing; and 4) Discuss case examples and explore how to mitigate risk.

SUMMARY:
Death rates from drug overdoses have been steadily rising and now represent the number one cause of death in the United States, surpassing motor vehicle accidents. As a result, there is a national public health initiative to take efforts to curtail drug deaths and prevent drug diversion through the use of tougher laws and penalties for improper prescribing practices and the implementation of prescription drug monitoring programs in virtually every state. These initiatives, designed to safeguard the public health and safety while supporting the legitimate use of controlled substances, often result in psychiatrists interacting more frequently with pharmacies, law enforcement, and regulatory agencies. This workshop will define some of the risk management and liability exposures that psychiatrists must recognize when prescribing controlled substances, and case examples will be used to further illustrate potential liability exposures faced by psychiatrists when prescribing controlled substances to their patients. Psychiatrists may face a

difficult dilemma when prescribing controlled substances if they learn that the patient is being prescribed the same medication by another provider, when their patient was not truthful about what medications they are being prescribed or when it becomes apparent that the patient is misusing the prescribed medication. Psychiatrists often struggle with what to do: continue to treat the patient or terminate with the patient. This session will explore these issues, and risk mitigation strategies will be presented to help lessen the identified liability exposures.

Psychiatrists as Leaders: A Guide to Conflict Management

Chairs: Patrick S. Runnels, Serena Yuan Volpp, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe and understand structural conditions that cause conflict in the workplace; 2) Describe five style approaches to conflict; 3) Understand structural interventions to manage conflict; 4) Apply these concepts to real situations in their current work environments; and 5) Describe the benefits of broader leadership training as put forth in public and community psychiatry fellowships.

SUMMARY:

Over the past several years, the burden to our systems of mental health care is likely to grow, increasing the demand for capable and innovative leaders. Consequently, many current practitioners are likely to be offered leadership opportunities in the coming years, yet clinicians are offered almost no formal leadership training, and many individuals who are promoted to leadership positions struggle as a result. Public and community fellowships are among the only training programs in the country that offer intensive formal leadership training, but few people have any sense of what that training is like. In this workshop, we will focus on one area of leadership to better demonstrate the overall value of such fellowships. Everyone experiences conflict in the workplace, especially as health care reform leads to increased pressures. Whether or not a psychiatrist is in a named leadership role, being able to analyze conflict and manage it is a critical skill. The presenters will describe conditions that lead to conflict. Participants will have an opportunity to identify their own approach toward conflict. Interventions to manage conflict will then be illustrated. Finally, participants will break out into smaller groups to practice managing a conflict scenario.

Sickly Hot: Clinical Consequences of Climate Change and How to Protect Your Patient

Chair: Elizabeth Haase, M.D.
Presenters: Robin Cooper, M.D., Elizabeth Haase, M.D., Janet L. Lewis, M.D., Sander Koyfman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand how higher ambient temperature changes the course of mental illness and the effects of psychiatric medications; 2) Incorporate new data on the neuropsychiatric impact of fossil fuel particulates and higher greenhouse gas concentrations into current understandings of the etiology of dementia, neurodevelopmental disorders, and other neurological conditions; 3) Examine the impact of recurrent extreme weather events using data from Hurricanes Sandy and Katrina and contributions from the areas of risk prediction, societal determinants of health, multigenerational trauma, and complicated bereavement; 4) Describe new psychoterratic syndromes such as solastalgia, ecoanxiety, and nature deficit disorder; and 5) Discuss possible clinical interventions using case scenarios and audience dialogue.

SUMMARY:

Climate change is as the greatest threat to global health in the 21st century. Rising global temperatures have caused more frequent natural disasters, accompanied by increases in posttraumatic stress, anxiety disorders, depression, and the psychiatric consequences of loss, financial distress, and forced displacement. Fossil fuel particulates that raise greenhouse gas production are inducing neuro-inflammation, increasing rates of dementia, stroke, and major depression. Heat itself brings unique risks that are particularly impacting psychiatric patients, increasing aggressive behavior and magnifying the

risks of psychiatric medication use and the higher rates of medical morbidities in the chronically mentally ill. The longer-term chronic impacts of environmental disruption and habitat loss that are occurring are associated with suicide, loss of identity and dissociation, solastalgia, and other disruptions to personality and biology that cut broadly across socioeconomic barriers. This didactic workshop will provide participants with an up-to-date review of the specific mental health impacts of climate change. The first panelist will describe the impact of greenhouse gases and fossil fuel particulates on the vasculature and brain, focusing on the clinical neuropsychiatric sequelae of this impact. The second panelist will discuss the direct impacts of higher temperature on the psychiatric patient: increasing violence and suicide, increased morbidity and mortality from specifically psychiatric medications, and factors common in the chronically mentally ill that contribute to risks of heat stroke and heat exhaustion. The third panelist will describe the long-term impact of extreme weather disasters, using data from hurricanes Sandy and Katrina. The fourth panelist will review psychoterratic syndromes including nature deficit disorder, solastalgia, and ecoanxiety. Each panelist will conclude with a case example and list of possible interventions, which will be opened up for audience discussion.

Using Measurement-Based Care in Psychiatric Practice to Improve Patient Outcomes
Chair: Jerry L. Halverson, M.D.
Presenters: Bradley C. Riemann, Ph.D., Eric A. Storch, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Understand how real-time outcome measures are being used in a large psychiatric system to improve care; 2) Choose examples of appropriate acute and longitudinal outcome measures for various psychiatric disorders; 3) Understand the appropriate use of broad crosscutting measures and more targeted measures; and 4) Understand measurement-based care and how it may improve performance on quality measures.

SUMMARY:
In order to be able to improve the care that we provide for our patients, we have to be able to measure it as objectively as possible. Measurement-based care (MBC) is one of the keys to improving the care provided to psychiatric patients. The nature of psychiatric disease and the relative lack of objective measures lends itself well to the use of patient- and physician-reported measurement-based care. Various measures can be used help diagnose and triage type of illness and level of severity and response to treatment. This workshop will discuss the use of MBC in psychiatric illness. We will discuss how measuring the care that you are giving can improve the care that you give, as well as how MBC is a core aspect of successful integrated care and how it can be used to improve physician performance on MACRA/quality payment plan measures. The benefits and the challenges of MBC in psychiatric settings will be discussed. The use of MBC in a large psychiatric system at the inpatient, residential, and outpatient levels of care will be discussed. We will present the design, upkeep, and use of both real-time and retrospective use of this data to improve patient outcomes in various psychiatric treatment settings. Case-based discussion will follow.

Violence 201: Advanced Clinical Strategies for Recognizing and Managing Violence Risk
Chair: John S. Rozel, M.D., M.S.L.
Presenters: Layla Soliman, M.D., Abhishek Jain, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Appreciate new evidence delineating which aspects of psychiatric illness are, and are not, associated with violence risk; 2) Explain the roles of unstructured clinical interviews, actuarial instruments, and structured professional judgments (SPJ) in various settings; and 3) Understand how threat management and protective intelligence approaches to clinical scenarios may yield new considerations in mitigating clinical violence risk.

SUMMARY:
Most people with psychiatric illness are not violent. Most violence is not attributable to psychiatric illness. People with psychiatric illness are more likely

to be victims of violence than perpetrators. While misunderstood by the lay public, psychiatrists know these aphorisms well, and the science that established them is as robust today as it was 20 years ago, but, fundamentally, these truisms offer little in the way of practical guidance about recognizing and managing people who are at risk for violence. This workshop is intended to remedy that need by providing attendees with practical, memorable, and effective techniques to recognize and manage violence risk derived from recent developments in the research of violence with particular attention paid to psychotic illnesses, applying structured clinical judgment tools, and integrating nonclinical models such as protective intelligence and threat management. **Psychosis and violence risk**: The old—and incorrect—wisdom said to look for command hallucinations and subtypes of delusions. New evidence points clearly to the issues of active symptoms in general, comorbid substance use, and medication adherence. Additionally, new research reinforces previously recognized trends of elevated risk to family members over strangers. **Beyond the actuarial versus clinical debate**: Structured clinical judgment and other hybridized tools provide a more flexible framework to guide the identification of highly leveraged risk factors and targeting of dynamic risk factors for intervention. **Think outside the box**: Law enforcement and protective intelligence intersect with behavioral science in an emerging field known as threat management. This field has an array of empirically derived models for recognizing, managing, and disrupting intended violence that can be particularly helpful in understanding risk related to psychiatric illness. This workshop will be led by three forensic psychiatrists, each anchored in different clinical settings including emergency work, consult-liaison, and inpatient. They will blend their forensic and clinical experiences to deliver an engaging and memorable framework.

Saturday, October 21, 2017

Advocacy Skills for Psychiatrists: From the Clinic to the Capitol

Chair: Michaela Beder, M.D.
Presenters: Marc Manseau, M.D., M.P.H., Flavio Casoy, M.D., Clement Lee, Esq.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of micro, meso, and macro approaches to addressing social determinants of health; 2) Gain practical skills in a diversity of advocacy approaches; and 3) Discuss challenges in balancing the roles of clinician and advocate.

SUMMARY:
We live in challenging times. Economic inequality is increasing both locally and globally. Governing systems are increasingly unstable, with the entrenchment of deep divisions within populations and the rise of extremist political parties. The social fabric is fraying as we witness both challenges to democratic institutions and the shadow of authoritarianism across the world. These international and societal dynamics correlate with health effects, from illnesses related to wars and refugee crises in the Middle East and Europe to rising suicide rates in economically marginalized areas of the European Union to a general increase in mortality in the United States. There is an urgent need to counter such difficult trends with evidence-based arguments for social justice, human rights, and health equity. Physicians in general, and psychiatrists in particular, are uniquely equipped to meet this critical need for advocacy. As physicians and mental health professionals, we bring a valuable perspective to social justice issues within both individual clinical encounters and society at large. We work with some of the most marginalized people and see daily the impact that poverty, racism, homelessness, insecure immigration status, and lack of access to health care can have on well-being. In this workshop, participants will have opportunities to learn about a framework for engaging in advocacy work to improve general health, promote health equity, and increase access to health care. Participants will gain practical skills in several advocacy methods, which can be used in clinical, local community, and government settings. At the micro level, we will review how psychiatrists can impact the social determinants of health (SDH), including by advocating on behalf of patients for access to care, housing, and social benefits. At the meso level, we will explore clinical and community-

level programs to address the SDH, and at the macro level, we will discuss how research, writing, political lobbying, community organizing, and protest actions can improve the social and economic conditions that affect the mental and physical health of our patients and the larger public. In order to have maximum impact, a diversity of tactics is needed to address upstream causes of poor health and to bring about social justice. Using case examples from the presenters' experience in Canada and the United States, including from advocacy on poverty and health, immigration detention, gun violence prevention, and access to health care, participants will take part in and facilitate an interactive discussion on opportunities for psychiatrists to take on advocacy roles. Doing so is not entirely without risk of professional repercussions, and there will be opportunity for discussion about balancing professional and advocacy roles.

Beyond the Launching Pad: A Forum for Planning for Life After Residency

Chair: Stephen M. Goldfinger, M.D.
Presenters: Marshall Forstein, M.D., Ellen Berkowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Have a clearer idea of how proceed with their careers after residency; 2) Describe the fellowship application process; and 3) Demonstrate the ability to discuss practice and job options.

SUMMARY:

The workshop organizers, who among them have decades of experience advising senior residents on issues of career trajectories, lifestyle choices, and post-graduation decisions, are offering this workshop as a "consumer-driven" place to bring your questions about life after residency. Although virtually all residency training programs provide thoughtful and well-designed didactics and clinical supervision, we have found that residents around the country consistently struggle with issues—and the lack of information—about what to do after residency is over. The sorts of topics that we hope you will bring for discussion include Is doing a fellowship essential? How about if I want a career in academia? Does taking a non-accredited fellowship make sense? When should I start looking for jobs? Is it like interviewing for residency? What should I be asking about besides salary and hours? Should I change towns or stay where I trained? Why? Everyone keeps warning me the entire health care system is changing. How do I prepare for that? How does one set up a private practice? Should I look for salaried or self-employed positions? Does anyone do psychoanalysis anymore? Can I have an academic career and still earn a decent living? I want to be a ___. How do I get there? I'm on a J-1 visa. What are my options? These are, of course, not meant to be a comprehensive list, but are the kinds of questions we'd be happy to (help) answer!!

Motivational Interviewing in Working With Patients With Serious Mental Illness

Chair: Michael Flaum, M.D.
Presenters: Brian Hurley, M.D., M.B.A., Florence Chanut, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the core components of the "spirit of MI" and their resonance with the core concepts of mental health recovery; 2) Discuss the four meta-processes of MI and the potential barriers of each in working with patients with SMI; 3) Identify opportunities to apply MI to address and overcome common clinical scenarios characterized by ambivalence about change or discord (e.g., medication nonadherence); and 4) Begin to apply MI skills in the clinical care of patients with serious mental illness.

SUMMARY:

This workshop will discuss the potential advantages of using motivational interviewing (MI) in working with patients with serious mental illness (SMI). Dr. Flaum will discuss some fundamental ideas underlying the rationale for MI and its resonance as a communication style with a recovery-oriented versus medical model approach. Dr. Hurley will introduce workshop participants to the core skills of the Four Processes and Recognizing Change Talk and the relevance of these skills to general psychiatric practice in patients with SMI. Dr. Chanut will discuss and demonstrate key reflective listening skills,

including the use of open-ended questions, affirmations, reflections, summaries (OARS), and techniques for informing and advising in an MI-consistent manner. Workshop participants will be asked to practice these skills in guided exercises using real-world clinical scenarios in working with patients with SMI (e.g., around issues of treatment adherence). The session will conclude with a discussion of how to incorporate these MI skills into everyday practice.

Share Your Wisdom: Using the ECHO Model to Mentor PCPs and Expand Access to Care for Behavioral Health Disorders
Chair: Miriam Komaromy, M.D.
Presenter: Eric R. Arzubi

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe the use of the ECHO model to expand access to behavioral health care; 2) Draft a proposal to use the ECHO model to share their wisdom by mentoring PCPs in behavioral health care; and 3) Understand the difference between the ECHO model and other approaches to expanding access to behavioral health care.

SUMMARY:
Numerous studies have documented the need for improved access to behavioral health care and the importance of integrated physical and behavioral health care. Nevertheless, these remain elusive goals in our health care systems, in part because of scarcity and maldistribution of psychiatrists. The ECHO model offers an approach to expanding access to care by engaging psychiatrists and other behavioral health providers as expert mentors and consultants for primary care providers (PCPS) and teams, thereby expanding the expertise of the PCPs in addressing patients' behavioral health problems. ECHO programs use videoconferencing to simultaneously connect multiple primary care team members (the "spokes") with specialists (the "hub") and builds capacity via ongoing mentorship and, most importantly, case-based learning. The model also serves to triage high-complexity and high-need patients who need referral to psychiatric care. This workshop will discuss the experience that the ECHO Institute has gained over the past 11 years using the ECHO model to build capacity to address substance use disorders and mental health disorders and the benefits for primary care teams and patient care. We will also discuss the programs implemented by an ECHO "hub" at the Billings Clinic in Montana that uses ECHO to expand and enhance treatment for mental health disorders for prisoners. Most recently, the ECHO Institute received funding from HRSA to support a nationwide program—Opioid Addiction Treatment ECHO—that is offering teleECHO clinics focused on treatment of opioid use disorder, aimed at supporting primary care teams in HRSA-funded federally qualified health centers (FQHCs). This program is offered out of five separate specialty "hubs" (University of Washington, Billing Clinic in Montana, University of New Mexico, Boston Medical Center, and the Western New York Collaborative) and serves primary care teams from FQHCs from across the U.S. We will describe our first year of experience with this program. We will also discuss the differences between the ECHO model and well-known and effective alternatives, such as the collaborative care model. Then participants will have an opportunity to break into guided small groups to draft a plan for how they could develop an ECHO program to serve the needs in their own state or region. Finally, the group will share ideas and brainstorm about how to use this powerful model effectively.

The Veterans Affairs Mental Health Delivery System: Integrated Clinical Care and Population Health Combined
Chair: Harold Kudler, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Clarify need for integration of mental health services across a broad continuum of care settings including Primary Care clinics; 2) Argue for the full integration of mental health and substance use treatment within a single delivery system and a unified electronic medical record; and 3) Define the essential link between clinical and population health models in reducing Veteran suicide and avoiding fragmentation of care.

SUMMARY:
The unique mission of the U.S. Department of

Veterans Affairs (VA) has required it to become the world's largest, most comprehensive integrated system of mental health care and, in addition, one of the largest population mental health systems. To achieve the needed scope, continuity and quality of care, VA has overcome unnatural divisions in mental health delivery which, none-the-less, persist across most other systems. These include (but are not limited to) the interfaces between: delivery of services by psychiatric, psychological, social work and other disciplines; inpatient, outpatient and residential mental health care; mental health and substance use services; mental health and primary care, and; VA and community care. The modern VA system grew out of the experience and advocacy of World War I military psychiatrists who realized that no other organization had the mission, the scope of skills or the resources necessary to meet the mental health needs of Veterans. A full century later, VA continues to pursue this mission through the delivery of clinical care, research and teaching. VA also plays a key role in response to national emergencies and to major public health issues including the current epidemic of suicide among Veterans, military service members and all Americans. Of special significance, VA's mission has always incorporated a population health approach to mental health; a perspective to which the nation is only just awakening. This workshop will explore VA's history, policy and current operations and provide ample time for give and take among participants in order to clarify why every clinician in the nation needs to have basic military cultural competence and a practical working knowledge of the VA mental health system.

Sunday, October 22, 2017

Collaborating With Service Users to Transform Mental Health Professional Education: Going Upstream to Redefine Effective Care
Chair: Sacha Agrawal, M.D., M.Sc.
Presenters: Stephanie Le Melle, M.D., M.S., Rebecca Miller, Ph.D., Serena Spruill, Michaela Beder, M.D., Kim McCullough, B.S.W.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe the potential impact of collaborating with service users to transform mental health professional education; 2) Plan for some of the challenges involved in implementing a service user educator model; and 3) Outline an opportunity for collaborating with service user educators in their local context.

SUMMARY:
Calls for the transformation of mental health and addiction systems to better support recovery emphasize the need for mental health professionals to support choice, instill hope, and foster self-determination and empowerment. The changes required of the mental health professional workforce to enable these improvements are as yet poorly characterized but are likely to be substantial. One promising educational innovation that is gaining ground is the service user educator model, wherein service users (i.e., people with lived experience of mental health and/or substance use challenges) are positioned not in their traditional roles of objects of study but as active collaborators in education at all levels, including formal instruction, curriculum design, assessment, and educational oversight. Proponents of this model argue that service user educators are uniquely positioned to convey the lived experience of recovery and facilitate a critical analysis of services and that their involvement represents a powerful opportunity to combat prejudice at early and critical stages of professional training. The presenters will review the service user educator literature with a focus on co-production as a conceptual framework for collaboration. Next, they will describe their experiences and evaluation data from collaborations with service user educators for diverse groups of learners (psychiatry residents, fellows, and frontline clinicians) at three academic centers (Columbia, Yale, and Toronto). Opportunities for making a powerful system impact as well as implementation challenges will be highlighted. Last, participants will be guided in drafting a plan for increasing the level of involvement of service user educators at their own institutions.

Improving Public Health Impact Through Mental Health Services Research: Funding Priorities and Tips From the National Institute of Mental Health
Chair: Michael C. Freed, Ph.D.
Presenters: Susan T. Azrin, Ph.D., Denise Juliano-Bult,

Denise Pintello

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Discuss high funding priority areas for NIMH services research; 2) Present an overview of the NIMH's experimental therapeutics paradigm that is required for all services research involving clinical trials; and 3) Field questions related to funding priorities, available funding mechanisms, and submission of meritorious applications.

SUMMARY:
As the largest funder of mental health services research in the United States, the National Institute of Mental Health (NIMH) is committed to supporting meritorious services research. The constantly changing health care landscape creates new challenges to the delivery of high-quality treatments and services to children, youth, adults, and older adults with unmet or undermet mental health needs. Epidemiological findings suggest that approximately one half of the U.S. population meets lifetime criteria for a mental disorder, and approximately one quarter of the population meets criteria in any given year. However, only one half of people with any mental health disorder and only two thirds of people with a serious mental health disorder received mental health services in the previous year. Of those who find their way into mental health care, many fall out of care and/or do not receive guideline-concordant treatment. Disparities in population status, a fragmented health care system, provider shortages, health care affordability, and other factors moderate the likelihood of accessing and remaining engaged in high-value mental health services. Transformative mental health services research is needed to improve access, continuity, quality, equity, efficiency, and value of mental health services; to bring effective strategies and practices to scale; to sustain them; and to ultimately maximize public health impact. The NIMH seeks innovative research that will inform and support the delivery of consistently high-quality mental health services to benefit the greatest number of individuals with, or at risk for developing, a mental illness. The pathway of evidence can be thought of as discovery to delivery, but the NIMH also sees discovery out of delivery as part of a continuously improving health care system that is crucial to improving the nation's public health. Here, the translation of findings is bidirectional. Service system leaders, providers, health care beneficiaries, and other key stakeholders drive research questions so that seminal research findings will dramatically influence practice change. In this workshop, NIMH program officials will discuss high funding priority areas for mental health services research to include the following: suicide prevention, autism spectrum disorder services, reducing the duration of untreated psychosis, integration of mental health into primary care and other nontraditional settings, leveraging technology, dissemination and implementation science, research involving children, systems of care, new methods, financing, disparities, and research networks. In addition, they will present an overview of the experimental therapeutics paradigm, which is required for all services research involving clinical trials. Finally, program officials will field questions related to funding priorities, grant mechanisms, and other relevant topics to encourage potential applicants to submit competitive applications.

Prescribing Clozapine: The Nuts and Bolts of Successfully Using an Underutilized Medication
Chair: Robert Osterman Cotes, M.D.
Presenter: Anthony Battista, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Identify appropriate indications and candidates for clozapine use; 2) Understand how to start clozapine, including dosing and strategies to manage and mitigate common and life-threatening side effects of clozapine; and 3) Develop strategies to improve clozapine utilization in one's own practice setting.

SUMMARY:
Clozapine remains one of the most effective pharmacological tools in treatment of persistent symptoms of psychosis. Although it is estimated that up to 20-30% of individuals with a diagnosis of schizophrenia could potentially benefit from clozapine, only five percent are actually prescribed this medication. Administrative burden, lack of coordinated laboratory or specialist services, and

both consumer and prescriber concerns are commonly cited causes of underutilization. Through an interactive discussion using several case vignettes, this workshop will provide the prescriber practical information to use clozapine with greater confidence. Highlights will include discussion on the indications, efficacy, side effect profile, titration strategies, drug-drug interactions, use of the REMS system, and strategies for adjunctive treatment to clozapine. Finally, in a small group format, attendees will develop strategies to optimize and increase clozapine utilization in their own system of care.

Specialty Care in Integrated Care: Providing Integrated Care for Pediatric Mental Health
Chair: Robert Hilt, M.D.
Presenters: William P. French, M.D., Cecilia P. Margret, M.D., Ph.D., M.P.H., Erin Dillon-Naftolin, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, the participant should be able to: 1) Describe models of integrated care for pediatric mental health (PMH); 2) Discuss curriculum development for child mental health topics relevant for integrative care and describe education strategies to engage adult learners based upon adult learning theory; 3) Demonstrate improved consultant expertise for common pediatric mental health disorders and topics; 4) Describe challenges and important implementation considerations for PMH integrated care; and 5) Develop an individualized plan for enhancing integrated care support for pediatric providers depending on type of clinical setting most relevant for the participant's current or planned practice.

SUMMARY:
Over the last 20 years, models of integrated care—defined as care provided by a team of health professionals working together to coordinate and deliver behavioral health services in primary care settings—have been demonstrated to improve health care outcomes in adult populations. More recently, there is a growing movement to implement integrated models in pediatric populations due to clear evidence that specialty care workforce shortages, ongoing mental health stigma, lack of care coordination, and other systemic problems have contributed to a growing crisis in pediatric mental heath care, with an estimated four in five youth with mental health problems unable to receive the care they need. Integrated care models seek to address these barriers by improving pediatric access to behavioral health care services through delivering and coordinating care via psychoeducation and consultation to primary care providers. Pediatric integrated care models have been shown in randomized clinical trials to be feasible and cost effective and, most importantly, to lead to superior health care outcomes compared to usual care. They also lead to reduced mental health stigma as youth and families are more willing to seek mental health care delivered in their medical homes from their primary care providers who, by having ongoing consultation with mental health specialists, are able to gain confidence and improve their knowledge and skills in delivering mental health services. While the demand for integrated care is growing, training for psychiatrists in how to provide this care is lagging behind, particularly for youth. Through the new state-funded University of Washington Integrated Care Training Program, we have developed a curriculum for teaching core components of child and adolescent psychiatry to adult psychiatrists who plan to work in integrated care settings and may be asked to provide support to pediatricians and family medicine providers. The first part of the workshop will be an overview of the core principles and team structure of integrated care in pediatric mental health. The following section will review the 3 main variants of integrated care models currently in development: 1) coordination; 2) colocation; and 3) collaborative care. The third section will focus on curriculum development and learning strategies for adult learners for a selected sample of pediatric mental health disorders and related topics. Following this, we will break out into small groups based upon the disorders and topics discussed in the third section, from which attendees may choose to learn topics relevant to their practice. We will then regroup to review the implementation strategies and challenges involved in setting up integrated pediatric mental health consultation practices. Last, attendees, along with a facilitator, will again break into smaller groups to design individualized integrated care models.

Teaching Medical Students About Psychiatry: Planting the Seeds for Integrated Care

Chairs: Ann Hackman, M.D., Constance Lacap, D.O.
Presenters: Vedrana Hodzic, M.D., Marissa Flaherty, M.D., Curtis Adams, M.D., Benjamin Ehrenreich, M.D., Jamie Spitzer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify some of the challenges to teaching psychiatry to medical students; 2) Recognize at least three novel ways to introduce students to psychiatry; and 3) Implement techniques to reduce stigma around psychiatric illness and treatment and prepare medical students to work in integrated care settings.

SUMMARY:

Integrated somatic and psychiatric care is a model that optimizes access to psychiatric care for those who need it. To create and sustain an integrated system and facilitate access to psychiatric care, it is essential to begin with medical student training. Most medical students begin with little knowledge of psychiatry and a perspective fraught with stigmatizing attitudes held by many and perpetuated by entertainment and media. Additionally, students have limited understanding of the relevance of psychiatry to other fields of medicine. To facilitate the development of young physicians committed to integrated care, training should focus on creating early, positive experiences with psychiatry faculty and residents, on addressing and reducing stigma around psychiatry and psychiatric diagnoses, on facilitating education about psychiatry in a nonjudgmental environment and on exposing students to the broad world of psychiatric treatment. At the University of Maryland School of Medicine, an urban training site in Baltimore providing treatment for many impoverished and underserved individuals, we have undertaken some innovative approaches to medical student training in psychiatry. Exposure to psychiatrists often begins prior to acceptance, with many faculty members serving as interviewers and on the admissions committee. One member of the psychiatric faculty introduces the incoming class to the city of Baltimore with a bus tour including socioeconomically deprived neighborhoods. Students have opportunities for additional exposure to psychiatry not only with a traditional psychiatry interest group but also with an intensive elective course, the Combined Accelerated Psychiatry Program, a specialized longitudinal program of 50 years' duration designed for interested students. The second-year psychiatry didactics focus on increasing awareness and reducing stigma, as well as teaching the basics. Students participate in an exercise in simulated auditory hallucinations and hear stories of personal experience and recovery from people living with the diagnoses students have learned about in the lecture halls. Each second-year medical student does an individual interview of a person currently receiving psychiatric treatment with our division of community psychiatry. Broad exposure to inpatient, outpatient, and emergency psychiatry, as well as elective experiences with ACT and private practice, continue into the clerkship and clinical years. At each step in this process, educators from the department of psychiatry assess student feedback and focus on the importance of a good understanding and respect for people with psychiatric diagnoses and symptoms in all areas of medical practice. This workshop will consider relevant literature, describe and explain approaches in our program, and, with our audience, consider these and other strategies for preparing young physicians to practice fully integrated care and thus expand access to care.

Treating Survivors of Intimate Partner Violence (IPV): Improving Access to Care With an Integrated Service Model

Chair: Mayumi Okuda, M.D.
Presenters: Elizabeth M. Fitelson, M.D., Obianuju "Uju" J. Berry, M.D., M.P.H., Rosa Regincos, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the common barriers to mental health care for intimate partner violence (IPV) survivors and the rationale for trauma-informed services for this population; 2) Summarize clinical, legal, and training recommendations that can improve access to care for IPV survivors; and 3) Discuss the benefits of a multi-specialty collaborative model that effectively treats IPV survivors' multiple needs.

SUMMARY:
Intimate partner violence (IPV) is a major public health problem that results in a wide range of short- and long-term adverse mental health consequences. In the general population, approximately 20% of individuals who experience IPV within a year develop a new psychiatric disorder. IPV survivors compared to those free of IPV are four times more likely to attempt suicide at some time in their lives. In selected samples such as domestic violence shelters, the prevalence of PTSD and MDD has been reported to be as high as 84% and 61%, respectively. Despite the elevated rates of co-occurrence of IPV and mental health problems, there is significant evidence that the mental health needs of IPV survivors continue to be unmet and that these problems are heightened among minority groups. IPV survivors often feel misunderstood, unsupported, and even blamed when they interact with the mental health care system. Such negative experiences can perpetuate a damaging cycle of revictimization and mistrust. Furthermore, in spite of the well-recognized urgency to increase mental health resources for trauma survivors in the U.S., most mental health professionals do not receive formal education and training in trauma-related mental health. Trauma and IPV are not routinely included in the professional training of most psychiatry and psychology programs in the United States. The presentation will describe common challenges in working with this population including safety issues, revictimization, and providers' challenges, including lack of competency in trauma treatments and vicarious trauma. This presentation will illustrate lessons learned throughout the development and expansion of a program that integrates mental health services with community-based ones for IPV survivors, as well as describe the development of a training and supervision model for mental health clinicians caring for IPV survivors in these settings. The presentation will also provide a platform for discussion on ways to increase awareness of and training on IPV/non-combat trauma and how to enhance the national capacity to provide mental health services for this population. This workshop will be presented by a team of professionals in the fields of advocacy, social work, psychology, and psychiatry who have experience working with IPV survivors in a wide range of settings. At the conclusion of the workshop, the participant will be able to discuss practical strategies that can improve access to care, as well as learn about a model that provides integrated services to IPV survivors and other non-combat trauma survivors.